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Transition to Practice of the Advanced Practice Registered Nurse in the Long-Term Care Setting: An Ethnography

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Transition to Practice of the Advanced Practice Registered Nurse in the Long-Term Care Setting: An Ethnography

by

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Dedication

To my husband Steve. Wow, what a journey we have been on together. I couldn't have asked for a more understanding and supportive life partner. Thank you.

To my children Molly, Aaron, and Claire. You are amazing children with so much promise and potential. I am grateful for your understanding on those nights when I couldn't tuck you in, or we had to eat take-out (yet again). I am proud that I could show you what dreaming and hard work can accomplish. I look forward to watching you grow and find your own path in life.

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Abstract

Transition to Practice of the Advanced Practice Registered Nurse in the Long-Term Care Setting: An Ethnography

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Americans are living longer and suffering more complex care at the end of life, which often requires admission in a long-term care environment. With a projected shortage of physicians trained to care for this population, advanced practice registered nurses (APRN) are stepping in to fill this care void and should be supported in their transition to practice (TTP) in this unique practice environment.

Using ethnographic methods, I applied the principles of complexity science and complex adaptive systems as a sensitizing theoretical framework to explore the experience of a cohort of APRNs as they transitioned into practice in the Long-Term Care (LTC) setting. Observations and interviews, as well as a purposive sampling of individuals working in the LTC setting were conducted as part of a collaborative study between The Texas Health & Human Services Commission (TXHHS) and the Center for Excellence in Aging Services and Long-Term Care (CEASLTC) within the School of Nursing at the University of Texas at Austin. I employed an iterative process to adapt

observations and interview techniques, updating questions as needed to capture the intended phenomena of interest. Credibility and trustworthiness were reinforced through field notes, journaling, check-backs with participants as themes were identified, and frequent consultations with an academic advisor.

Five themes were identified: 1) Establishing Legitimacy, 2) Institutional Acceptance, 3) Personal Role Fulfillment, 4) Provider Relationships and 5) Individual Care vs. Organizational Care. These themes have implications for how to design transition programs that meet the needs of APRNs in this novel practice environment. APRN preparation should be reexamined to emphasize the APRN role in organizational care as well as individual patient care. Physician, APRN relationships should be reimagined to promote autonomy and bolster instead of impede transition. The roles and responsibilities of providers delivering care in the LTC setting should be re-envisioned to provide truly patient-centered care and to allow APRNs to fill the unique niche encompassing both nursing care and medical care. This study revealed facilitators and barriers to APRN TTP in the LTC environment and suggestions are proposed for improvement and future investigation into roles, responsibilities, education, and mentorship of the TTP experience for APRNs.

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Background, Significance and Study Overview

Introduction

The goal of this research is to understand the experiences of advanced practice registered nurses (APRN) as they transition into a new practice environment in the Long-term Care setting (LTC); specifically, to learn the values, beliefs, and behaviors of the APRNs that made their transition process fit with the goals of the organization. This chapter provides background and significance of the problem, significance to nursing including rationale for the study, purpose of the study, research questions, rationale for the qualitative mode of inquiry and a review of the guiding framework.

Background and Significance of the Problem: Why are Nurse Practitioners Needed?

Globally, persons 65 years or more represent the fastest growing demographic (United Nations [UN], Department of Economic and Social Affairs, Population Division, 2019). North America and Europe have the largest proportion of people in the world with 18% of citizens over 65 and 38% over 80 years of age (UN, 2019). In the United States, the number of citizens 65 and older is projected to double by 2060 to nearly 95 million and will rise to 23% of the total population (Mather et al. 2015). The baby boom generation, defined as those currently between ages 55 and 73, is predicted to be responsible for a 50% increase in the number of Americans over 65 requiring nursing home care: up to 1.9 million in 2030 from 1.2 million in 2017 (Mather et al., 2015). As people age, with some exceptions, they become more medically complex with challenging comorbidities and disability requiring more specialized care (Bednash et al., 2011). This demographic promises to put continuing strain on the U.S. health care system and require

creative strategies to ensure cost-effective and effectual care. The APRN holds promise as a potential workforce solution to provide care to this challenging demographic.

In 2018, the US spent 17.7% of its GDP on healthcare, more than two and a half times the amount per person than other comparable developed countries, however quality indicators show comparable outcomes (Kane, 2012; Centers for Medicare & Medicaid [CMS], 2019). Several potential sources for disproportionate cost have been proposed, including hospital mergers that reduce competition, increasing technologies, higher physician pay due to low practitioner supply, excess administrative costs, and a reimbursement system which rewards number of procedures, not outcomes or quality of care (Kahn, 2010; Burton et al., 2017; Price Waterhouse Cooper [PWC], 2018). All of this culminates in a care system that is expensive and yet fails to meet the care needs and create a healthy country.

In 1999, the Institutes of Medicine (IOM) issued their seminal report *To Err is Human: Building a Safer Health System*, which underscored the previously unidentified high number of medical errors which contribute to poor patient outcomes, deaths, and higher costs of care (To err is human, 1999). This report also suggested that the know-how to solve these problems already exists and involves a mix of organizational roles, regulations, care coordination and professional practice (To er is human, 1999). The eye-opening statistics contained in this report spearheaded renewed focus on improving the quality of US national healthcare, resulting in a multitude of follow-up consensus statements including *Crossing the Quality Chasm: A New Health System for the 21st Century*, *Health Professions Education: A Bridge to Quality*, and *The Future of Nursing: Leading Change, Advancing Health*. (To er is human, 1999; Crossing the quality chasm, 2001; Greiner & Knebel, 2003; The future of nursing, 2011). All of these statements focused on various aspects of the problem identified in the original *To Err is Human*

report, and all attempted to further identify how Nursing as a profession could work to help solve these challenges, including allowing APRNs "to practice to the full extent of their education, training and competence" (To err is human, 1999; Crossing the quality chasm, 2001; Health professions education, 2003; The future of nursing, 2011, p.4).

Long-Term Care Industry

Long term care (LTC) services, including nursing home (NH) care, currently accounts for 40% of Medicaid spending in the U.S. and is responsible for 16% of national healthcare expenditures (NHE) in 2018 (Centers for Medicare [CMS], 2020). Medicare which covers medical care necessary for those in LTC settings currently accounts for 21% of NHE and grew by 6.4% in 2018 (NHE Fact Sheet, 2020). Medicare is expected to experience the greatest spending growth between the years 2019-2028, with an expected 7.6% rise, due to increases in projected enrollment reflecting our aging US population (CMS, 2020). National health expenditures are also projected to outpace the national gross domestic product (GDP) by 1.1% per year between 2019-2028 causing a rise in the health cost share of the economy from 17.7% to 19.7% (CMS, 2020).

The LTC industry has not received the attention needed to curtail rising costs in the last decade; especially when compared to attention given the acute care industry. These cost curtailing efforts are clearest in the legislation passed. In 2010, the US Congress attempted to address general healthcare costs and care quality concerns with the passage of *The Patient Protection and Affordable Care Act* (ACA) (The Patient Protection and Affordable Care Act, 2010). This legislation has three primary goals including increased access to care, improved quality of care, and to reduce the costs of care (Collins & Saylor, 2018). The provisions passed in ACA focused mainly on acute and primary care settings, and LTC provisions focused mostly on

care outside of the LTC institutional setting and prioritized care in home and community-based services (HCBS). (The Patient Protection and Affordable Care Act, 2010; Barth et al., 2011; Center for Healthcare Strategies, 2013). The Hospital Readmissions Reduction Program (HRRP) aims to keep down hospital readmissions and assigns penalties for hospitals for each patient readmitted too frequently which incentivizes hospitals to only work with LTCs that avoid these readmissions (Collins & Saylor, 2018). Accountable Care Organizations (ACOs) are organizational agreements to better coordinate patients across levels of care to provide efficient and quality services, but these ACOs have mainly focused on partnerships with short-stay Skilled Nursing Facilities vs. custodial Nursing Homes (Collins & Saylor, 2018). Similarly, Bundled Payments for Care Improvement (BPCI)) plans encourage organizations to band together to provide care with bundled payments shared between the organizations instead of fee-for-service, therefore encouraging efficiencies in care for a greater share of revenue (Collins & Saylor, 2018).

New models of care are clearly needed to achieve the seemingly disparate goals of improved patient care at reduced costs, and APRNs can fill this role. Though APRNs have been a part of the healthcare system for over 50 years, further work is needed to negotiate and define their role (Judge-Ellis & Wilson, 2017). Through increased focus on identifying a networked model for care which recognizes the influence and interactions of different professionalism levels such as organizational environment, legislation, socio-economic influences, and patient perceptions, on the ability of APRNs to assume care: APRNs can be more fully defined and therefore recognized and utilized as distinct care providers with their own body of expertise (Niezen & Mathijssen, 2014). Furthermore, Advanced practice registered nurses are a cost-effective alternative that promises to lower US national healthcare expenditures. APRN

compensation rates are considerably less than physician rates, at one third to one half per hour, and have remained consistent for 30 years since initially identified by Office of Technology Assessment (American Association of Nurse Practitioners [AANP], 2013). The proportion of non-physician visits by Medicare patients for evaluation and management, either performed by APRNs or physician assistants (PA), grew from 4.6% in 2010 to 12.3% in 2017 (Auerbach et al., 2020). APRNs can be considered not just substitutes for physician care, but complementary by "adding a new care service" which straddles the cure and the care aspects of healthcare (Niezen & Mathijssen, 2014, p. 153).

All of these challenges and changes presented by the ACA, are opportunities for APRNs to step in and provide the care needed to achieve these efficiencies and improve patient outcomes. Nursing's unique theoretical foundations allow for a truly patient-centered approach due to grounded training in "biophysical, psychosocial, and developmental knowledge" (Luther & Hart, 2014, p.309). Nurses serve many functions in the health care delivery systems, from front-line caregivers, health promotion, disease prevention, and as regulatory experts making them uniquely qualified to fulfill the three aims of the ACA (The future of nursing, 2011; Luther & Hart, 2014). The 2011 IOM report *The Future of Nursing: Leading Change, Advancing Health*, identified four recommended focus areas for nurses to provide the change necessary to guide healthcare into the next century which will help nursing meet the challenges set forth by ACA. These include the need to achieve higher levels of education to become the next generation of caregivers, to create policies to allow nurses' to practice to the full extent of their educational level, for nurses to become full care partners with other health professionals and finally, to focus on policymaking which emphasizing development of an effective healthcare workforce (The future of nursing, 2011).

Significance to Nursing: Nurse Practitioner as Quality Caregiver

Advanced Practice Registered Nurses (APRN) have provided quality care in the United States for over 50 years across a wide variety of care settings (Delamaire & Lafortune, 2010; AANP, 2018). According to the 2008 "Consensus Model for APRN Regulation: Licensure, Accreditation, Certification & Education", an APRN in the U.S. is a registered nurse (RN) who has undergone further clinical education to build upon their foundational practice to utilize a greater depth of knowledge to synthesize patient information into more complex skills and interventions requiring greater role autonomy (APRN Consensus Work Group, 2008). Nursing practice at all levels is governed in the U.S. by each individual state law, and any nurse practicing "beyond the identified scope of nursing practice" must be legally permitted and defined by each state, regardless of title or national certifying body (National Council of State Boards of Nursing [NCSBN], 2020).

The individualized state responsibility for APRN practice has led to various applications of practice law, individualized from state to state. In 2008, 41 organizations published a consensus model meant to provide guidance and further define advanced practice nursing across all states (APRN Consensus Work Group, 2008). According to this model, an APRN practices in one of four specialties: certified registered nurse anesthetists (CRNA), certified nurse-midwives (CNW), clinical nurse specialists (CNS) or certified nurse practitioners (NP) and in at least one of six population foci: families/individuals, adult-gerontology, pediatrics, neonatal, women's health/gender-related or psych/mental health (APRN Consensus Work Group, 2008).

To guide APRN practice in the U.S., four essential elements were identified in the 2008 Consensus Model for APRN regulation in the U.S. including: licensure, accreditation, certification, and education (LACE) (APRN Consensus Work Group, 2008). Education occurs at

a graduate level and each program must be accredited by a recognized higher educational governing body with the purpose of preparing students for a certification examination. Once certification is achieved, licensure can then occur at the individual state level granting the nurse permission to practice according to the laws set forth in the state Nurse Practice Act (NPA) (APRN Consensus Work Group, 2008). However, unlike physician education, once the APRN has obtained licensure, there is no expected residency period prior to starting practice as defined by the state (Association of American Medical Colleges [AAMC], 2019).

Nurse practitioners (NP) make up the largest subgroup within the APRN workforce in the U.S. with an estimated total of 68.7% of the 439,527 RNs with advanced training in 2019 (U.S Department of Health and Human Services [HHS], 2018). The Certified Nurse Specialist (CNS) make up the second largest group with an estimated total of 19.6% of the 439,527 RNs with advanced training (HHS, 2018). Certified Nurse Anesthetists and Certified Nurse Midwife (CNM) come in at a distant 3rd and 4th, with 9.3% Certified Nurse Anesthetists and 2.4% CNMs in a 2018 National Sample Survey of Registered Nurses (NSSRN) survey (HHS, 2018). Both the CNM and the CRNA role have very distinct role and patient population differences than the other two categories of APRN whereas CNS and NP practice contains a great deal of overlap (Kenward, 2007; Donald et al, 2010). A survey conducted by the NCBSN in 2007, queried APRNs to determine which activities were most highly rated by each role to delineate similarities and differences between the practical application of the two roles. Both NP and CNS's shared similar activities centered around the critical thinking aspects of nursing care, including clinical diagnostics, and determining the appropriate treatment modalities in developing a plan of care. However, the same survey found differences in that NPs are more focused on direct patient care activities such as examinations and writing orders, while CNSs are

more concerned with more administration-level activities such as working as part of an interdisciplinary team, promoting patient advocacy, and utilizing evidence-based research (Kenward, 2007).

The US Bureau of Statistics projects that the NP workforce will increase 26% by 2028, while the American Association of Medical Colleges projects the supply of physicians will only increase by 0.5% by 2030 (Bureau of Labor Statistics, 2020; AAMC, 2019). By 2030, there are projected to be 2 NPs for every five physicians and rapid growth in Advanced Practice Providers (includes both APRNS and Physician Assistants) is projected to partially offset the projected physician shortage, (AAMC, 2019; Auerbach et al., 2020). According to the 2018 AANP National NP Sample Survey, 11.6% of NPs reported having privileges in LTC settings, and 66.5 percent of NPs reported seeing patients 86 years of age and older (AANP, 2018). APRNs are currently the most common type of nursing home specialist, when analyzed as a representation of specialists per 1000 beds, 3.21 compared to 1.37 for physicians (Ryskina et al., 2017). Meanwhile, physicians specializing in geriatrics demonstrated a population-adjusted decline of 23.3% in 2018, at a time when the number of individuals above 65 is anticipated to grow 55% by 2030 (Petriceks et al, 2018; AAMC, 2019).

While the reasons for this shift in primary care provider demographics is complex, several reasons cited include: physician reduced working hours, increasing physician education focus on specialization instead of primary care, physician early retirement due to burnout as well as a proliferation in advanced practice nursing education (Dalen et al, 2017; AAMC, 2019). In 2011, the Institute of Medicine (IOM) report *The Future of Nursing: Leading Change, Advancing Health,* called for nurses to be able to practice to the full extent of their education and licensures which would allow for the most efficient and effective patient care model (IOM,

2011). APRNs are uniquely suited for caring for geriatric populations with their unique educational foundation with equal consideration of psychosocial caring and physical biological systems (Luther & Hart, 2014).

The American Association of Nurse Practitioners (AANP) states that:

> *"What sets NPs apart from other health care providers is their unique emphasis on health and wellbeing of the whole person. With a focus on health promotion, disease prevention, and health education and counseling, NPs guide patients in making smarter health and life-style choices, which in turn can lower patients' out of pocket costs."*

(AANP n.d. section: Unique Approach). In 2016, the National Organization of Nurse Practitioner Faculties (NONPF) and the American Association of Colleges of Nursing (AACN) published population specific competencies for all Acute and Primary Care NPs and CNSs trained to care for adult-geriatric populations (American Association of Colleges of Nursing, The National Organization of Nurse Practitioner Faculties [AACN, NONPF], 2016). Likewise, they also published recommended competencies for APRNs who do not care for primarily geriatric populations in order to ensure a consistent standard of care for those who provide care to older adults even if it is not their primary focus (AACN, 2010). Therefore, all APRNs regardless of specialization, are trained to care for these special geriatric populations.

Several pivotal studies focusing on APRN quality of care have shown a consistent message that APRNs provide equal or better care than physicians with similar positive outcomes (Ploeg et. al, 2013; Rantz et al., 2014; Rantz, et al., 2017; Poghosyan et al., 2018; Blackburn et al., 2020). Nursing's unique ability to develop relationship-based and person-centered care increases their ability to provide improved quality of care (Ploeg et al., 2013). A 2014 evidence

brief published by the Veterans Affairs (VA) administration found no difference in care between APRNs and physicians in 4 outcomes measures: health status, quality of life, mortality, hospitalizations; which led to a policy change in 2016 allowing APRNs full independent practice in VA hospitals (McCleery et al.,2014; U.S. Department of Veteran Affairs [VA], 2016). Bauer (2010), reported that NHs where NPs provided primary care were able to realize cost savings, and Kane, Keckhafe, Flood, Bershadsky & Siadaty (2003) found a savings per NH of $103,000 per NP. In multiple studies, NHs employing NPs realized fewer ER visits and hospitalizations (Aigner et al., 2004; Buchanan et al.,1990; Burl et al., 1994; Burl et al., 1998; Rantz et. al, 2014; RTI Inc, 2017; Blackburn et al., 2020). Though NPs perform more patient consultations, and on average take longer, Swan et al. (2015) found that costs were comparable to physician encounters. Aigner, Drew & Phipps (2004) identified how APRNS can save physician costs through time savings by assuming routine visits and therefore could provide complementary as opposed to competitive care.

Despite literature pointing to the efficacy and efficiency of APRN care in the US LTC setting, and recommendations by the National Academy of Medicine (formerly called the Institute of Medicine) and the National Council of State Boards of Nursing, APRNs only have full practice authority in 23 out of 50 states (AANP, 2021). These 23 states have passed legislation permitting APRNs to diagnose, prescribe and generally apply higher level thinking processes to assigning and managing patient care without requiring the co-signature and/or review of care provided by a contracted physician (AANP, 2021). State health rankings from 2012 demonstrate the ranking of care provided per state was closely correlated with full scope of practice for APRNs, implying better outcomes in states with full scope of APRN practice (Oliver et al., 2014). Similarly, scope of practice was also positively correlated with lower

hospitalization rates and improved health outcomes, as well as increases access to care (Oliver et al., 2014; Xue et al., 2016). In fact, increased supply of APRNs alone does not appear to account for increased healthcare utilization, but instead must be paired with increased scope of practice (Xue et al., 2016).

One criticism of NP practice is the lack of a formal residency program, similar to the physician process of on-the-job training provided by experienced accredited programs and paid for by CMS. On average, APRNs have practiced for 10 years or more, yet there are a growing number of APRNs with less than five years' experience (AANP, 2018). The proportion of new graduates increases every year with the increased numbers of academic programs (Auerbach et al., 2018; Salsberg, 2018). However, unlike physician training, there is no nationally recognized formal orientation experience for APRNs, including those practicing in an LTC setting, such as a residency or onboarding modules (Auerbach et al., 2018).

State health departments and legislative bodies have created varying legislative requirements for transition to practice (TTP) periods or practical experience for NPs, while some have no onboarding requirements before granting limited or full license authority (Scope of Practice, 2020). Most state TTPs are only focused on supervised practice periods under collaboration with a physician, but no evidence exists to demonstrate that these programs are effective for APRNs preparing to practice within their own scope above what they received in their graduate-level education programs (NCSBN, 2014, p. 6). In fact, several of these TTP oversight programs have added costs to the healthcare system and in the states with no physician oversight period prior to independent practice, no safety issues have been identified (NCSBN, 2014, p. 6). Current quality indicators require attention to both quality and cost making it beneficial to require what is most likely to improve patient safety.

There is evidence that some types of TTP may be beneficial. A formal orientation period was identified as more important to the nurse's transition than years of RN experience, which indicates that some form of TTP support could be beneficial (Barnes, 2015). Beneficial TTP programs also emphasize benefits in the form of reduced turnover and reported increased confidence in their practice (Spector et al., 2015; Goode et al., 2016). The need for TTP programs in LTC settings is clear, yet the reality of achieving national or state wide TTP is complex without CMS providing equal TTP funding and oversite as given to the physicians. Similarly, the ideal structure and length of a TTP program has yet to be identified leading to the need for more research and understanding of LTC facility transition programs.

In summary, the need for more LTC healthcare providers is growing along with the aging population in the United States while at the same time the number of physicians trained to care for this population in decreasing. APRNs have proven to be a cost-effective and quality caregiver for most patient populations and the number of APRNs training in the field of geriatrics is growing. Further research needs to be done to understand how best to support APRNs as they transition to practice into the LTC setting so that quality care can be provided for this demographic.

Purpose of the Study

The Texas Health & Human Services Commission (TXHHS) and the Center for Excellence in Aging Services and Long-Term Care (CEASLTC) within the School of Nursing at the University of Texas at Austin collaborated on a Centers for Medicaid and Medicare Services (CMS) Civil Moneys Penalty (CMP) grant (Interagency Contract, 2017). Funding was provided to understand the experiences of APRNs as they transition into a new practice environment in the Long-Term care setting. Specifically, the impact of the transition on both the APRN and the

reciprocal impact of the APRN on the nursing facility was studied. Through ethnographic interviews and observations guided by a complexity science theoretical framework, I sought to understand the transition experience of a cohort of APRNs over the period of one year, with a lens towards identifying APRN LTC transition challenges and facilitators.

Implications for Future Practice

This study is significant because it: 1) explores the transition experience of APRNs new to the LTC setting; 2) focuses on improving care of older adults in the face of increasing patient numbers and cost in the LTC setting with the aging population in the U.S.; 3) seeks to understand the facilitators and barriers to a successful APRN transition. The findings from this research can then serve as the foundation for improved TTP program design which can lead to better APRN retention and utilization in the LTC setting. This study also addresses the 2011 IOM's call to action by identifying how healthcare delivery in the U.S. can tackle the four main issues for nursing practice through successful transition into practice:

1. Nurses should practice to the full extent of their education and training.
2. Nurses should achieve higher levels of education and training through an improved education system that promotes seamless academic progression.
3. Nurses should be full partners, with physicians and other health professionals, in redesigning health care in the United States.
4. Effective workforce planning and policy making require better data collection and information infrastructure. (The future of nursing, 2011)

Research Questions

AIM 1: What are the experiences of APRNs as they transition into a new practice environment in the LTC setting?

RQ1.1- How does the practice environment influence the APRN transition?

RQ1.2- How does the APRN presence transform the practice environment?

Guiding Theoretical Framework

"Stop trying to change reality by attempting to eliminate complexity" – David Whyte (MacLeod, 2019)

Complexity science (CS) is the sensitizing, theoretical framework I used to guide this study. CS is characterized by complex adaptive systems (CAS), in which agents in a system come together in a "dynamic and nonlinear fashion" causing order to emerge from these interactions (Colon-Emeric, et al., 2016). CASs are fluid, emerge organically and self-organize as individual components reorganize themselves within a system (Lindberg & Lindberg, 2008). The environment helps to create self-organization through feedback, which helps the system to organize from within (Crowell, 2016). This organization from within also allows for the system to mount a collective response which leads to organizational responsiveness and evolution of the system (Chandler et al., 2015). The researcher will approach the transition of the APRN as a CAS which is embedded within a larger CAS of patient care systems in the LTC environment. This approach is valid as APRNs bring their own individual components to their TTP, respond differently to their different environments, and will react differently as they encounter different attractors; specific points that alter the trajectory of a system (Crowell, 2016).

Nursing systems have long been researched from a reductionistic, Newtonian, cause-and-direct-effect perspective; a relic left from the Industrial age when healthcare became institutionalized and was viewed as a machine (Wiggins, 2008). In reality, these systems function in changeable, disorderly, and nonlinear patterns with multiple unpredictable effects and feedback loops that cannot be understood by examining the constituent components (Burns,

2001). The whole cannot be viewed as a sum of its parts, but instead is different and greater than and therefore cannot be understood if parsed (Turner & Baker, 2019). The assumption that change occurs in a rational and linear fashion has limited research into social systems by discounting variance, when variance is, in actuality, a hallmark of change (Braithwaite et al., 2018). This realization that top-down, mechanistic ways of creating policy and practice improvement were insufficient, led to a search to understand the chaos of all systems, including healthcare, using a different lens and the birth of Complexity Sciences (Lindberg & Lindberg, 2008; Braithwaite et. al, 2018; Turner & Baker, 2019).

CS is not a single theory, but instead a worldview consisting of multiple interdisciplinary frameworks and theories all comprised of non-linearity, evolution (self-emergence) and adaptability (Mitchell, 2009, p. 14). Complexity science has emerged from a social science tradition of general systems theory (GST) where "elements that act in concert to produce some results are studied" (Yawson 2013, pg. 56). Von Bertalanffy (1972), one of the founders of GST, describes a system where effects can be explained by the actions and interrelationships between its constituent components. In general, these systems are considered closed and bounded in that they are protected from external environmental forces and its outcomes are maintained as part of the system (Tuner & Baker, 2019). Processes are considered to be reversible or irreversible, however in the case of irreversible systems, change becomes unsustainable as components of the system are consumed changing the system as a whole (Turner & Baker, 2019). When considering studying social systems, including nursing and healthcare systems, we are interested in unbounded systems which limits the usefulness of GST to study these systems.

Complexity science (also known in the literature as complexity theory or CAS) emerged as a response to the limitations of GST. In reaction to the limitations of reductionist research, CS

emerged as a discipline focused instead on ways to identify complex behavior arising from interactions, better suited for social research (Chandler et al.,2015; Turner & Baker, 2019). Though they maintain several parallel concepts, GST is useful for explaining patterns in nature which are bound, reducible and predictable, whereas CS is a better theoretical fit for systems in which social rules and constituents change rapidly and evolve creating new and dynamic structures (Turner & Baker, 2019). The social world is different from the natural ordered world, in that humans can act upon free will with intention, which ultimately creates and responds to a chaotic and evolving environment in a mutually interacting fashion (Boyatzis, 2006; Kramer et al., 2013). Interactions between the subcomponents of a system involving people with self-determination interact with the environment in an open system and the outcomes emerge as a new system entity determined through self-organization- the whole is different and greater than the sum of its parts (Zimmerman et al., 1998; Anderson & McDaniel, 2008; Turner & Baker, 2019). Interactions and feedback processes create phenomena that act to dampen or amplify change with emergent element properties that are "not properties of the individual elements themselves" (Ramalingam et al., 2008, p. 8)

Complexity science involves CAS, which emerge from relationships and interconnectedness of system components instead of through understanding of individual components (Benham-Hutchins & Clancy, 2010). CAS is generally used to describe the actual systems made up of acting members that relate to each other and the environment, learning and changing in nonlinear directions as well as the process by which systems organize (Anderson & McDaniel, 2008; Chandler et al., 2015; Turner & Baker, 2019). These systems are considered emergent, dependent on a "human-environmental process" involving phenomena which is

"complex, dynamic, relational, non-linear, structurally similar, integral, pandimensional, holonomic, difficult to study, *qualitative*, (and) self-organizing" (Davidson et al., 2011, p. xxxii)

Within a CAS, *complex* indicates the system is composed of agents; multiple and varied yet connected through many interactions and relationships (Lindberg & Lindberg, 2008). *Adaptive* indicates that these agents are flexible with the ability to learn and change in relation to, and independent of one another (Lindberg & Lindberg, 2008). *System* indicates that the system must be considered holistically instead of through its constituent parts, as agents within the system are interdependent and interactive (Lindberg & Lindberg, 2008). The system can only be understood through the patterns of relationships between constituent agents and not the agents themselves (Anderson et al., 2005).

The qualities of interdependence and flexible interaction give rise to several of the main features of CASs including *distributed control, emergence, self-organization, co-evolution,* and *attractors* (Zimmerman et al., 1998; Anderson & McDaniel, 2008). *Distributed control* indicates that no central mechanism or agent guides the CAS. Instead, the constituent agents exert distributed control through adaptation and the ability to learn new strategies from each other determining the direction and characteristics of a CAS (Zimmerman et al., 1998). In fact, centralized control would only slow down the ability of the system to learn and adjust, and instead the system is guided by a shared sensemaking among the agents (Begun & White, 2008). Individual agent performance is still important, yet the totality of the system performance cannot be explained by understanding individuals (Zimmerman et al., 1998).

As a result of distributed control, agents within a system learn and adapt with each other into fairly stable patterns that are not "governed by hierarchical intent" in a process of *co-evolution* (Anderson & McDaniel, 2008. p. 74). Regularity in a system arises from within the

system itself and this organic change is not "dictated by a central source" (Nelson & Staggers, 2014, p. 24). *Co-evolution* of the system is prompted by an *attractor,* which is a stimulus (physical or more intangible) that draws energy towards itself. *Attractors* cause a change in the trajectory of a CAS that can be either subtle or overt and can result in feedback loops which dampen or enhance outputs (Braithwaite et al., 2018). However, the change and direction of trajectory cannot be predicted (Zimmerman et al., 1998; McKeon et al., 2006). Agents within the system re-organize, co-evolve and adapt in response to the attractor(s) leading to emergence of the CAS (McKeon et al., 2006).

Self-organization of the CAS proceeds as agents interact with the environment and with each other and guides the system towards *emergence* (Anderson & McDaniel, 2008; Crowell, 2016). *Emergence* is the development of system characteristics, which again springs from an internal process of agent interactions and is not imposed by one or two leaders either within or outside of the system (Anderson & McDaniel, 2008). Emergence can be seen as both the process through which a CAS develops structure as well as the CAS structure itself (Anderson, et al., 2005). A connectionist perspective means that the focus on connections and interactions amongst the individual components of a system results in emergence as the components self-organize into a functioning system (Turner & Baker, 2019). All of these processes proceed simultaneously in a non-linear fashion, informed by feedback and feed-forward loops as agents relate to each other and their environment and evolve together (Zimmerman et al., 1998; Anderson & McDaniel, 2008). The lack of centralization in a CAS makes co-evolution difficult to map and adds to the unpredictability of CAS emergence (Zimmerman et al., 1998). McDaniel, Jordan and Fleeman (2003) argue that this unpredictability or "surprise" of a system is actually a hallmark of

unbounded systems, cannot be controlled or avoided, and can instead lead to creativity and new ways of understanding (p. 266).

Successful healthcare organizations embrace change and work to recognize and optimize reaction(s) to attractors by focusing on problem-solving processes not just individual solutions (McDaniel et al., 2003; McKeon et al., 2006). Emphasis on flexibility and relationships among agents grounded in a CS viewpoint, creates room for systems to evolve and rapidly cycle through improvement changes. A CS viewpoint also values diverse teams with varied experiences that allows for a more comprehensive understanding of the various agents within the CAS resulting in better collaboration and teamwork (McKeon et al., 2006; Wiggins, 2008).

Braithwaite et al. (2018) argue that CS and understanding of CAS are useful ways to understand and implement evidence-based science in healthcare as knowledge uptake is rarely straightforward. First, CS can help the researcher to better understand the extent of the problem to be addressed with a change in practice based in evidence. Second, CS can help to illuminate the influences which alter the proposed implementation plan for evidenced-based science. Finally, CS can help the researcher to evaluate any implementation plans by providing a framework to understand the system's response and allow for modification (Braithwaite et al. 2018). Uncertainty is a natural consequence of complexity and lack of knowledge because prediction becomes impossible (Begun & Kaissi, in McDaniel & Driebe Eds, 2005). Healthcare delivery systems, and healthcare professionals can theoretically reduce uncertainty through increased knowledge, though complexity of the system will always preclude elimination of surprise from uncertainly (Begun & Kaissi, in McDaniel & Driebe Eds, 2005).

CAS can also be used to understand individual, provider- level adaptation within a larger organizational level CAS such as the patient care encounter. Benham-Hutchins & Clancy (2010)

identify networks of care providers as embedded CASs with each provider acting as their own CAS embedded within a larger system-level CAS, called the Embedded CAS Conceptual Model (ECCM). By approaching understanding healthcare teams in this embedded fashion, researchers can better examine and identify individual as well as system level CASs and understand their interactivity in a social network such as patient care (Benham-Hutchins & Clancy, 2010). This approach is useful for this study as it allows for consideration of the APRN as a CAS with individual components of knowledge and actions within their own profession, personality, experience and education. As the APRN undergoes transition, their individual situation will contribute in various ways to enhance or inhibit their TTP in the LTC setting as they adapt and emerge, just as the care team within the LTC in which the APRN works can also be considered a CAS itself. Envisioning the APRN as an embedded CAS allows for conceptual framing of multiple factors that can be observed and remarked upon using behavioral ethnographic observations.

Complexity Science and CAS are a relevant approach to understand the transition of APRNs into practice in the LTC setting. Systems within which nurses work, are irreducible wholes and outcomes can only be understood in the context of interrelationships and non-linear, interdependent wholes (Hannigan, 2012). Similarly, APRNs are irreducible wholes and the interrelationships of their personal experiences with transition will illuminate their TTP in the LTC setting. Various experiences, environments, and relationships along the APRN transition can act as attractors causing the overall APRN as CAS to evolve and emerge with different characteristics. Because of the nature of attractors, small stimuli may have outsized effects which can only be understood by reviewing the interactions within the CAS holistically (Lindberg & Lindberg, 2008). CAS have noteworthy variation from one setting to the next, so even though

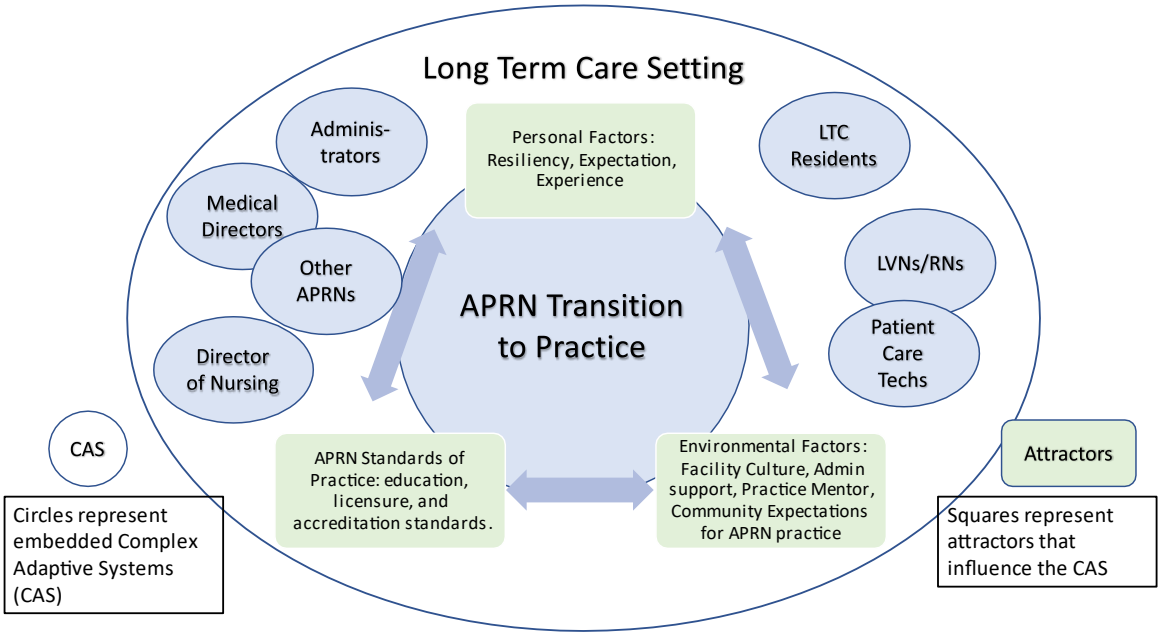
these APRNs are onboarded using the same concepts and are participating in the same program, CS will provide a sensitizing framework from which to understand how APRNs transition to LTC in the first year of practice (Braithwaite, 2018).

Complexity Science is also a useful way to understand the uniqueness of nursing as a caring science and to understand how the CAS can enable or endanger APRN caring through the transition experience. Person-environment relationships are essential to understanding how nurses can facilitate health and therefore understanding these systems is fundamental to understanding nursing (Newman et al., 2008). Nursing has many theories which reflect upon many concepts of CS. Starting with Rogers (1970) Science of Unitary Human Beings (SUHB), which describes people and environment as energy fields, without boundaries that continually evolved and emerge into creative systems. Here the system is irreducible to its component units and instead can only be understood in a holistic manner. Roy (2011) in her nursing adaptation theory, even positions a person as an adaptive system borrowing greatly from CS and CAS to describe how person and environment interact to create integration and creation of human consciousness. Turkel and Ray (2000; 2001) further focused on the complexity of the current health care environment, not just individuals in the mid-level Theory of Bureaucratic Caring (Ray, 2018). The environment in which care is given is driven by economic, regulation and cost factors which influence nursing practice. However, nursing practice is rooted in caring paradigm with primacy on relationships. This causes a necessary reconciliation between two competing forces which ultimate creates a "codetermined" relationship, aka attractors and emergence (Turkel & Ray, 2001). This emergence has the potential to allow for both the economic and caring paradigms to realize their full potential as the co-emerge to enhance patient well-being and nursing satisfaction (Ray, 2018).

The theoretical model illustrated in Figure 1, was used to inform the choice of ethnography methodology to investigate APRN transition to practice in Long Term Care settings (Figure 1 is inspired by a model proposed in Benham-Hutchins and Clancy (2010), *Social Networks as Embedded Complex Adaptive Systems*).

Figure 1:

Theoretical model of APRN transition as embedded CAS

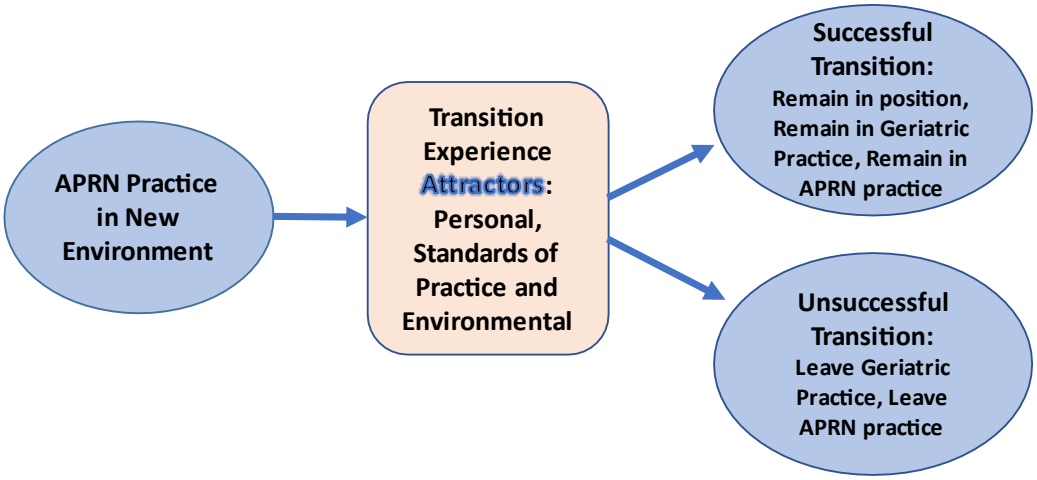


By staging the APRN as an embedded CAS within the larger LTC patient care CAS, research can then be planned to understand the system as a whole with a focus on how attracters alter emergence through process and structure. By understanding the APRN using the ECCM as an embedded CAS within a larger CAS, it is possible to understand intentional transition and the influence of interdependent relationships between the individual and group characteristics. It is problematic to illustrate a complex system using a two-dimensional model which more closely resembles the traditional linear approach; however, it is useful to visualize and illuminate a planned method to conceptualize how the researcher will approach the question. A qualitative

approach using ethnographic observations and interviews allows for interpretation and observation of the individual as an embedded CAS undergoing transition within a patient-system CAS. Observation and understanding of the APRN as an embedded CASs will help illuminate transition as they co-evolve and emerge within the LTC system. This theoretical model then informed the development of an operational model (See Figure 2) as a "necessary step in going from the broader complexity theory to manageable research questions and hypotheses" (Anderson & McDaniel, 2008, p. 75). This model postures personal factors, nursing standards of practice and environmental factors during transition as potential attractors altering nursing practice, but also leaves room for further clarification of the model as more information is elucidated during ethnographic data collection.

Figure 2:

Operational model of APRN Transition to Practice



Rationale for Qualitative Mode of Inquiry

The methodology that will be used in this study is ethnography. Ethnographic methods are warranted as a review of literature revealed a gap in understanding of how APRNs

experience transition into the LTC setting (see Chapter 2). When a phenomenon is little understood but can be guided by a general theoretical idea such as CS, then ethnography is an appropriate methodological approach. Ethnography is suitable to any research intending to derive "contextualized" meaning from observation to understand a phenomenon (Ravitch & Carl, 2016, p.221). The main approach to gather data occurs in the "contexts of (their) daily lives" through observations and interviews to understand the participants perspective (Durdella, 2019, p. 97).

Ethnographic observations are based on symbolic interactionism, where human actions are understood in the context, "people understand the world symbolically but also understand themselves as symbolic and symbol-using beings" (Rock, 2010, p. 29). Humans are confronted with situations that require them to interpret, define and act upon these situations based on their perception and the meanings attached to different items or circumstances. Consciousness organizes information into personal facts which are "necessarily interpretive and experiential" (Rock, 2010, p. 27). Each individual will bring their own "history, society, and psychology" and defines their situation individually (Rock, 2010, p. 27). It is through observing participants use of, and action upon symbols (experiences, encounters, and self) that give meaning to situations and can lead to interpretation by ethnographers through assignation of patterns and themes.

Ethnography lends itself well to a CS lens in that the research seeks to "generate a holistic description" of a group and their patterns of social life in a culture which is "dynamic and changing"- much like a CAS (Durdella, 2019, pp. 97-98). Instead of using a linear theory to search for pre-determined patterns which the researcher is *supposed* to notice, the ethnographer can instead build patterns by observing interactions and connections using CS to guide observations of non-linear systems (Agar, 2004, p. 16). Thought is considered purposive and individual actions are defined by the interactionism around an object, encounter, or situation.

These thoughts are “emergent”, part of a process, activity, and reaction to the world around it which “cannot be simply reduced down to its initial conditions” (Rock, 2010, p. 28). Much as CS embraces the interactions and relations in a complex adaptive system that emerges from non-reducible origins, ethnographic observations based in symbolic interactionism should not be reduced to “initial conditions” but instead focuses on the actions that emerge from participants personal interpretation of the world in which they interact (Rock, 2010, p. 28).

Observations and interviews were used to explore the experience of APRNs who are transitioning to a new practice environment in LTCs., to understand the experience more fully in order to improve these processes. With a focus on symbolic interactionism and how culture is jointly created, I used both interviews to understand individual subjects’ perspectives, but also personal observations to situate their meanings within observed contexts. The two approaches synergistically contributed to an iterative process which simultaneously unearthed more information and facilitated a fuller analysis to better understand the transition of APRNs to practice in the LTC setting.

Defined boundaries helped to limit analysis to the identified research questions and avoid scope creep into analyzing other aspects of nursing care not related to the case. Boundaries were created to concentrate focus on the realm of created reality related to the research questions focused on APRN transition.

Table 1

Boundaries for Ethnographic Approach

Within Boundaries	**Outside Boundaries**
APRN undergoing a transition experience	Transition of non-APRN personnel
LTC Administrators in charge of APRN transition to practice	Patient experience with APRN
Medical Director with medical agreement allowing APRN to practice in LTC setting	Unit barriers that inhibit ability of non-APRN personnel perform roles
Perspective on how facility culture contributes to transition	Perspective on nursing standards
How does facility culture influence ability of APRN to perform role	
How does the regulatory environment influence ability of APRN to perform role	

A conceptual or operational model was used to both guide data collection and assist with analysis. The ethnographic method is iterative in nature, so this model and interview questions were then, in turn, refined and further developed as analysis led to a better understanding of the experience of the APRN transition to practice. Ethnography is best approached without "presume(ing) too much in advance" in order to let shared meanings emerge from work in the field (Rock, eds Atkinson et al., 2010, p. 29). Theory in this study was used not to test hypothetical predetermined facts, but instead to assist the me as the ethnographer to use "theoretical knowledge to make sense of the new data uncovered in the field research" (Wilson & Anmol, 2010).

In summary, this chapter revealed the need for more healthcare providers for the aging populations cared for in LTC settings. Those 65 years or more are the fastest growing demographic in the U.S., but the percentage of physicians training to care for this population is decreasing. At the same time, the percentage of RNs training for advanced practice is growing and multiple pivotal studies show the care they provide is equal to, if not better than, the care provided by physicians. APRNs are a promising resource for care provision in the LTC

population, but more must be known about optimal TTP programs to understand barriers and facilitators to this process. This study was designed using ethnographic methods with CS and CAS as the sensitizing framework in order to understand the APRN transition experience in an LTC setting, as well as the reciprocal response of the LTC environment to the presence of the APRNs. By viewing the APRN as a CAS I can observe and envision the attractors that alter the course of TTP, while simultaneously envisioning the LTC care environment as a CAS which is necessarily affected by the presence of the APRN. By studying these interactions, information derived through qualitative observation and interviews may provide insight into the transition process and how to better support APRNs, LTCs and the populations they serve.

Chapter 2:

Literature Review: APRN Transition to Practice

Introduction

This chapter will present an overview of the relevant literature on APRN transition to practice (TPP) and the status of APRN led care in the LTC setting. More specifically, this literature review will position the APRN as a leader the LTC setting, as well as review what is known in the literature about APRN transition to practice. Once features of transition are evaluated, further investigation into the status of TTP programs for APRNs will be examined. As little is known about APRN TTP specifically into the LTC setting, this review will substantiate the need for further research into this topic. Through better understanding of how APRNs transition into LTCs, better systems can be designed and implemented resulting in better care for residents in LTC homes.

ARPN lead care in the Long-term Care Setting

Long-term care (LTC) is identified as an environment designed to meet "a range of services and support for your personal care needs. Most long-term care is not medical care. Instead, most long-term care is help with basic personal tasks of everyday life like bathing, dressing, and using the bathroom, sometimes called activities of daily living" (U.S. Department of Health and Human Services [HHS], 2017a, para 1). LTC can be provided in the home or in a residential facility such as a nursing home or nursing facility (NF). These services can be covered through either private insurance, disability insurance, or Medicare/Medicaid under certain circumstances (HHS, 2017b). CMS will differentiate between long term care services, which cover daily care and is reimbursed by the jointly state/federal managed Medicaid program,

versus medical care which is reimbursed by the federally run Medicare program when certain conditions are met (HHS, 2017c; HHS, 2017d). The medical care residents receive is usually paid for through Medicare, parts A, B, C & D and can include skilled nursing care and provider care through a physician or APRN. Medicare part B covers healthcare billing for skilled nursing care (SNF) in an LTC setting as well as to the physician and/or APRN for healthcare consultation and treatment when it is delivered and LTC setting (McGarry & Grabowski, 2019). Facilities can be dual certified for both SNF care through Medicare and daily NF care through Medicaid, causing much overlap between outcomes and the potential for interventions in one area to overrun into the other (Federal Register, 2016). Residents of LTC are, by definition, fragile, medically complex, and highly susceptible to functional and health crises, which indicates a need for quality nursing care and medical services. Through these reimbursement models, APRNs have provided competent healthcare to residents of LTC for over 25 years (Devereaux Melillo et al., 2015) and can serve as a cost-effective way to provide care with better or comparable patient outcomes (Oliver et al., 2014).

The addition of an APRN to the traditional Medical Director and/or treating physician model of care within a nursing facility (NF), has been shown to improve patient outcomes in LTC in a variety of ways such as improved outcomes and staff skills through training (Stolee, et al., 2006; McAiney et al., 2008: Rantz et. al, 2014; Blackburn et. al, 2020). States that encourage independent APRN practice have a lower rate, among LTC residents who are Medicare and Medicaid recipients, of hospitalization compared to states without independent APRN practice (Oliver et al., 2014). In 2012, Centers for Medicare and Medicaid (CMS) introduced a large initiative consisting of performance improvements in LTC settings across 7 state programs, called Enhanced Care and Coordination Providers (ECCP). These programs agreed to follow

various tenets set out by CMS to focus on reduced hospitalizations and other quality measures (ex. of all-cause hospitalizations, potentially avoidable hospitalizations, all-cause emergency department (ED) visits, and potentially avoidable ED visits) over a 4-year period, including mandated use of registered nurses (RN) or APRNs to support the program. Though each program applied the tenets in a slightly different manner, two employed APRNs specifically to address residents clinically with in-person visits as well as monitor quality data and five employed APRNs with varied responsibilities for program management and clinical care (RIT, 2017). An aggregate evaluation of all 7 programs found a statistically significant reduction in all-cause hospitalizations and potentially avoidable hospitalizations ($p=0.002$, $p<0.001$, 90%CI) which equates to a savings of approximately $760.00 dollars in Medicare spending, per resident, per year (RTI International, 2017). Though the 2 facilities with APRN-only clinical models found conflicting results of statistical significance in Medicare expenditure reduction (Missouri: -$1,241, $p=0.079$, 90%CI, Nebraska, $p= 0.188$, 90%CI), the three facilities that combined RN and APRN care all had significant reductions in Medicare expenditures per resident per year (RTI, 2017). For example, the Indiana *The Optimizing Patient Transfers, Impacting Medical Quality, and Improving Symptoms: Transforming Institutional Care (OPTIMISTIC*) project utilized APRNs who covered multiple facilities to partner with full-time, in-facility RNs in order to perform clinical evaluations, order care as needed, and review of residents transferred from the hospital (Unroe et. al, 2015). Ultimately, this intervention realized a reduction in risk of first all-cause hospitalization for NF residents of 16% in the first 18 months followed by a 26% reduction over the course of the 5 ½ years of data collection (Blackburn et. al, 2020).

Systematic Review of the Literature: APRN TTP

Transition to Practice

In the literature, Transition to Practice can refer to both RN level experiences as well as APRN level experiences (NCSBN, n.d.). Programs help newly graduating nurses transition from school to practice through reduction in the theory-practice gap, through an improved retention of new nurses, and finally, through improved resident/patient outcomes (Faraz, 2017; Eckerson, 2018; Rush et al., 2019). While TTP has been widely studied with the entry level nurse, less was found by this researcher on the transition of APRNs to practice (Kramer, 1974; Benner, 1983; Duchscher, 2008; Clipper & Cherry, 2015). For our purposes, we will address TTP from the APRN perspective as it is distinct and separate from the registered nurse TTP experience (MacLellan et al., 2015).

Contained within any TTP, is the concept of Transition. Transition is a process characterized by multiple phases, each requiring adjustment by the practitioner as well as adjustment of the team that has made room for the practitioner (Fitzpatrick & Gripshover, 2016). During the TTP, APRNs must philosophically modify the way they practice and cross boundaries to work both in the holistic tradition of their foundational training to a diagnostic and prescriptive mindset of a practitioner (MacLellan et al., 2015). TTP is a journey through which an individual travels from a place of comfort to a place of discomfort, insecurity, and unfamiliarity (MacLellan et al., 2015).

Transition is characterized as a form of complex and multi-faceted change that can only be understood by considering the thoughts and actions of an individual as it is situated in a social and cultural context (Zittoun, 2006). Socio-cultural theorists identify a framework for transition in which, the individual undergoing change must negotiate social contexts in which they operate

to realize a transition (Spoelstra & Robbins, 2010). This transition is not a moment in time, but instead is a process that is informed by social constructs, social context, historical and institutional settings (Crafter & Maunder, 2012). Wenger (1998) described a framework to understand a specific transition called Communities of Practice. This social theory identifies that learning occurs where social participation in a community of interest is required for learning to occur. This theory helps identify how a community of practice can influence not just what an individual knows, but also helps to shape and mold them into a practitioner and specify "who we are" (Wenger, 1998, p. 4). The community of practice has shared practices, rituals and standards which define behaviors in the search for common knowledge and goals (Wenger, 1998).

In the realm of educational psychology, Illeris' (2014) Transformative Learning and Identity theory hypothesizes that role transition occurs when an individual experience's a change in self-identity that requires development of new knowledge, new relationships, abilities and changes in normative behavior. Identity is formed through *transformative learning* and the individual experiences changes in self-perception and how they are perceived by others (Illeris, 2014). New learning is added to prior learning and further incorporated into the new identity (Illeris, 2014). Per O'Donnel and Tobbell (2007), learners prefer to actively participate in their own transitions and derive meaning by finding their own path to learn a particular skill or knowledgebase. Therefore, transition programs should be focused on allowing learners to construct their own sense and knowledge in order to transition successfully (Heitz et al., 2012).

Any nurse that returns to school to study how to become a nurse practitioner will undergo a role transition through this educational process. Transition will occur both in the school setting as well as post-graduation as the APRN solidifies their practice (Heitz et al., 2004). The first phase of transition occurs during education, and Phase II occurs as the APRN works in the field

in the first 6 months to 2 years after graduation. Both phases are defined by turbulence, but Phase I focuses on role-separation from their previous RN identity and Phase II focuses on role development into an APRN; though both are characterized by insecurity (Yeager, 2010). Yeager (2010) argues that APRNs go through the same Benner stages of experience restarting as a novice APRN even after attaining expert level as a nurse, although perhaps over a more compressed timeframe due to previous nursing experience (Hamric & Taylor, 1989).

Similarly, transition will occur with any established nurse that transitions into a new care setting. A review of literature did not identify any research into established APRN transition into new settings such as long-term care; however, it did identify a concept analysis of registered nurse (RN) "new-to-setting" transition (Chicca & Bindon, 2019). Gohery & Meaney (2013) identified negative emotions including anxiety and feeling overwhelmed, which emerged during an RN transition from acute to critical care, yet these symptoms improved over time. Mutual support from other nurses was identified as reducing these emotions and supportive preceptors also reduced emotional burden (Gohery & Meaney, 2013). These transitions are assumed to be different from a new to practice nurse in that they involve a lateral movement between settings; yet the transition is still characterized as non-linear and complex (Chicca & Bindon, 2019). This concept analysis also identified that the literature and current practice typically identify new-to-setting transitions as linear, which could indicate that nurses are not being supported as needed in lateral, but non-linear practice transitions. Similar concepts should be investigated in the APRN population, but no studies were identified that accomplished this analysis.

Brown and Olshansky (1998), identified four stages of APRN (specifically novice nurse practitioners, NPs) transition in their From Limbo to Legitimacy Theoretical model; laying the foundation, launching, meeting the challenge, and broadening the perspective. This process is

hypothesized to take about a year and ideally culminates in the APRN reflecting on their own practice, affirming their practice through feedback and taking on more responsibilities. External and internal stressors were also identified that can alter or delay the transition experience for new APRNs (Hill and Sawatzy, 2011). A particularly demanding stressor occurred when the new APRN was considered a pioneer APRN or only APRN in their work environment (Kelly & Mathews, 2001). Pioneer APRNs must spend a great deal of effort educating their coworkers to their role while still attempting to establish their own identity and practice. Isolated APRNs struggle to establish clinical competence without feeling connected to the APRN community at large, while also establishing their worth to their new workplace (Kelly & Mathews, 2001). Isolation risks diminishing the APRN enthusiasm for their new role and a greater focus on negative experiences, all serious risks to a successful transition into practice experience (Steiner et al., 2008).

Transition to practice (TTP) is characterized as a as a challenging time for practitioners as they struggle to identify their role and carve out a distinct position within their practice arena (MacLellan et al., 2015). Successful transition allows the APRN self-definition to emerge allowing development of identify and practice (Pop, 2017). TPP requires transition in which the nurse undergoes change in practice self and therefore intentional programs are recommended to facilitate this process.

Current State of TTP Programs for APRNs

Literature Search

To systematically investigate APRN transition to practice programs, database and ancestral search were used. No studies were found to address APRN TPP programs specifically in LTC settings, so the search was broadened to any APRN transition experience. Databases

included CINAHL, Medline, ProQuest, PubMed, GoogleScholar and Cochrane Library. Articles were discarded that if they were older than 10 years old unless they were considered seminal works. Search terms included *nurse practitioner, advanced practice nurse, advanced practice registered nurse, residency, transition, orientation, job satisfaction, long term care, nursing home, turnover, burnout, and mentoring.* Database and ancestral searches of reference list revealed 6 quantitative studies (Barnes, 2015; Dillon et al., 2016; Hart & Bowen, 2016; Faraz, 2017; Horner, 2017; MacKay et al., 2017) and 5 qualitative studies (Sullivan-Bentz et al., 2010; Elliott et al., 2017; Pop, 2017; Owens, 2018; Rugen et al., 2018) that fit the inclusion/exclusion criteria. United States and Canada were both included, while other English-speaking countries such as Australia and the United Kingdom were excluded, because their APRN practice model, regulation, and education expectations are similar (Pulcini, Jelic, Gul, & Yuen Loke, 2010).

Table 2

Literature Search Inclusion/Exclusion Criteria

INCLUSION	EXCLUSION
APRN (NP, CNS) Acute care, Community, or Long Term Care setting English Language US/Canada Academic Journal Qualitative OR Quantitative 2010-2020	RN, LVN, LPN, Nursing Students, MD, PA as main population Academic or Simulation Setting Not English Language Australia/UK/Korea/Israel Quality Improvement Program Descriptions Prior to 2010

Using content analysis, the included studies were aggregated into categories of like concepts and experiences to further illuminate the characteristics of transition to practice programs and their effect on the NP transition to practice experience (Krippendorff, 2004). Sorting and synthesis led to the emergence of 4 themes: (1) Mentoring as an essential part of a successful transition experience, (2) Organizational support is necessary to facilitate a successful

transition program. (3) Programs that facilitate intrinsic factors improve transition and satisfaction and (4) Creating autonomy leads to successful transition and increased satisfaction.

Mentoring

The importance of mentoring is well documented and all the TPP programs evaluated incorporated some form of formal or informal mentoring. Horner (2017) noted that 100% of participants reported a positive experience with their mentor. A retrospective survey of the transition experience in Hart and Bowen (2016) found that only 17% responded to having a formal assigned mentor, while 40% had informal mentors; however, there was no difference in perceptions of support based on type of mentor. In this study, 62.6% of respondents agreed or strongly agreed that adequate support was provided during the first year of clinical practice, yet 49% of respondents also reported feeling they practiced beyond their level of competence at some point during their first-year transition to practice (Hart & Bowen, 2016). There were significant differences across groups (rated for preparedness to practice from strong to weak on a 5-point Likert=type scale) and the satisfaction with support ($F=36.145$, $P<.001$) (Hart & Bowen, 2016). These findings were generated from a retrospective survey, which could skew the findings, yet these inconsistent findings demonstrate the value of having a mentor to potentially increase the safety of practice through adequate support (Hart & Bowen, 2016). Likewise, though Faraz (2017) found the quality of professional relationships was not a significant predictor of job satisfaction (B= -.12, p-.32), the study does not specify if these professionals are coworkers or mentors, confounding the implications.

A sample of nurses in an acute care NP program identified support from an APRN or physician mentor as vital when encountering new situations and procedures (Dillon et al., 2016). Timely feedback was important to APRN practice development and helped these participants to

develop confidence in skills and clinical decision-making (Dillon et al., 2016). Nurses self-identified that mentorship through exposure to various clinical settings and preceptors allowed for a better transition and achievement of APRN personal transition goals (both clinical and developmental (Rugen et al., 2018). Conversely, a lack of mentoring was identified via content analysis of open-ended questions, as a significant barrier to critical decision making with complex patients for those who did not have a formal mentor (MacKay et al., 2017).

A study using grounded theory methodology to identify ideal mentoring behaviors for an APRN transitioning into an acute care setting reported the process to be a journey that progresses through stages and negotiation. The ultimate outcome of establishing a mentorship relationship was a successful role transition "she (mentor) allowed me to become a nurse practitioner faster" (Pop, 2017, p.307). When combining findings from this grounded theory approach and previous research, Pop (2017) recommends using a combination of formal and informal mentoring to facilitate better relationships that have meaning for all parties involved.

In an analysis of TTP in rural settings, all participants reported a belief in the importance of a mentor but also reported a mix of formal and informal (Owens, 2018). The rural setting created an additional challenge in that due to the remoteness of the setting, many of these informal mentors were remote, not in person, and available only via phone. Rural APRNs are necessarily self-directed and reported slightly different challenges including feeling autonomous, but also anonymous. This combination of self-sufficiency and remoteness creates a distinct work identity from the APRNs undergoing transition in the less remote settings identified in the other identified studies.

Organizational Support

In order to develop and maintain successful TPP practices, organizational support was identified as a major facilitator (Sullivan-Bentz et al. 2010; Dillon et al., 2016; Hart, 2016). In a retrospective survey, Hart and Bowen (2016) identified that satisfaction with support demonstrated a significant relationship to the APRNs feelings of preparedness to practice ($F=36.145$, $P<.001$) with more satisfied associated with more feelings of preparation. When APRNs are newly hired into an organization Sullivan-Bentz et al. (2010) identified both the positive and the negative aspects that come from organization support. A qualitative descriptive narrative analysis revealed that it is essential for coworkers within the newly hired APRN practice to be familiar with the APRN role and understand how the APRN can work with the primary healthcare team. Poor understanding of the APRN role was associated with interprofessional competition and served as a barrier to APRN role integration (Sullivan-Bentz et al., 2010).

Organizational support starting with clear understandings of the APRN role was identified as a major benefit to a NP practice model adopted in a Texas hospital system (Elliott et al., 2017). The Transformational Advanced Professional Practice Model (TAPP) provided a useful framework for APRNs to structure their practice and created a way for APRNs to better communicate their practice throughout the organization though role clarity. The TPPM allowed for a definition of the APRN professional being and supported nurses to cultivate their inner self and intentionally recognize their inner satisfaction to be found in helping others. The organization supports the "innate passion to serve each other" (Elliott et al., 2017, p. 329).

Communication between disciplines can also be viewed as a version of organizational support in that the functioning of the team at a systems level can be facilitated or impaired by

effective avenues of communication. MacKay et al. (2017), noted that nurses identified lack of communication with the interdisciplinary team as a challenge and was reflected in 50% reporting a perception of feeling unprepared after the first year. Dillon et al. (2016), found a significant positive relationship between organizational support and intrinsic subscales including: comfort/confidence ($r=.049$, $P<.01$), patient safety ($r=0.38$, $P<.05$), professional satisfaction ($r=0.72$, $P<.05$), job satisfaction ($r=0.53$, $p<.01$).

Intrinsic Factors Support

Elliott et al. (2017), identified that internal motivation was enabled through adoption of an intentional APRN practice framework (TAPP) allowing for celebration and deliberate identification of nursing intrinsic factors. Transition of new APRNs was facilitated through the TAPP model through role clarity celebrating authentic practice increasing satisfaction with their role (Elliott et al., 2017). Intrinsic factors originating from the individual APRNs sense of self and purpose in nursing, were found to be positively associated with job satisfaction in Horner (2017). The subscales of the Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS) most closely associated with satisfaction are those related to internal pride with work itself; such as achievement, responsibility, advancement, potential for growth and recognition. This is as opposed to extrinsic factors such as salary status, security, policies, administration which are actually considered dissatisfiers and are associated with the highest levels of job dissatisfaction (Horner, 2017).

In the rural health setting, intrinsic factors actually drive the transition to practice experience as APRNs intentionally choose this remote practice environment (Owens, 2018). Though the APRN transition in this setting can be challenging, the desire to practice in a rural environment can minimize or at least help to overcome some of the challenges. Even though

these APRNs in transition can report feeling anonymous and overwhelmed, they also report feeling satisfaction with the personal relationships with their patients, fellow nursing staff, and satisfaction knowing that they are providing access to healthcare for rural patients who often go without (Owens, 2018).

A well designed TPP program can support and guide new APRNs to a successful transition by supporting the personal internal drive and functional domains. A successful transition was not related to personal resources outside the organization (ex. financial, familial), but were related to personal intrinsic factors driving personal satisfaction with self as an APRN (Dillon et al., 2016). In this study, there was a significant positive relationship between organizational support and intrinsic subscales which indicate successful transition including: comfort/confidence ($r=.049$, $P<.01$), patient safety ($r=0.38$, $P<.05$), professional satisfaction ($r=0.72$, $P<.05$) and job satisfaction ($r=0.53$, $p<.01$) (Dillon et al., 2016).

Autonomy

An important consideration in a TPP program is the development of APRN autonomy, especially in our current system which has varying degrees of autonomy based on practice environment (Xue et al., 2016). Professional autonomy is identified as an inversely significant predictor of turnover intention ($B= -.63$, $p<.001$) with greater levels of autonomy resulting in lower intention to leave and explained 40% of the variance in turnover intention (Faraz, 2017). Sullivan-Bentz et al. (2010) identified threats to autonomy and independent practice as serious threats to successful APRN transition. When physicians were the APRN employer, but also were unfamiliar with the APRN role, then both groups found the transition to be challenging. Professional territory battles resulted from these unclear roles and ultimately causes confusion among, and potentially less than optimal treatment of, patients (Sullivan-Bentz et al., 2010).

Owens (2018) investigated nurse transition in a setting unlike any of the other studies included in this review. In the rural primary care setting, autonomy was prized and at the same time almost required due to the remote nature of rural APRN practice. While APRNS transitioning to practice in rural settings expressed distress and at times feeling overwhelmed, the desire to practice in rural health helped them to overcome some of the distinct challenges of this setting. Self-direction and autonomous actions are necessary approaches in this transition and result in a unique professional identity development focused on skills necessary for rural health care. Though at times APRNs report feeling anonymous, this feeling is ameliorated by mentorship, even if remote, and by the satisfaction with autonomous practice (Owens, 2018).

Summary

This review shows that intentionally planned TTP programs are beneficial to APRN transition in terms of job satisfaction, reduction in intent to leave and assumption of a healthy APRN role identity. By allowing APRNs to "fulfill their personal and perhaps spiritual needs to serve others", TTP programs that allow nurse to articulate and use their intrinsic values that drive their practice will have better results for the APRN as well as the patient (Sullivan-Bentz, 2010; Elliott et al., 2017). For example, the TAPP model celebrates the unique contribution that a caring APRN healthcare model brings, which as Horner (2017) demonstrates, these intrinsic subscales are positively associated with job satisfaction. In other words, when APRNs are guided by invested mentors and allowed to practice autonomously fulfilling their desire to serve others then everyone wins: the organization through job retention, the APRN through role identity attainment and satisfaction, and pateints through better patient-centered care, free of interprofessional competition.

The diversity of methodology (qualitative and quantitative) of this review demonstrates that there is still room for discovery of transition experiences based on different practice environments. All studies of TTP investigated occurred in acute care, primary care or rural health environments. The six studies utilizing quantitative or mixed methods all either took place in an acute care setting or the setting was not specified or varied where the surveys were sent to organization members, not based on care sites (Barnes, 2016; Dillon et al., 2016; Hart & Bowen, 2016; Faraz, 2017; Horner, 2017; MacKay et al., 2017). Of the five qualitative studies, two were set in primary care settings (Sullivan-Bentz et al., 2010; Pop, 2017) and two were set in acute care settings (Elliott et al., 2017; Rugen et al., 2018). However, Owens (2018) was set in a very specialized environment, rural health, and is instructional for how to proceed to investigate APRN transitions in a variety of settings. Qualitative work is used to define emerging phenomenon, quantitative methods are then used to test these identified parameters (Creswell, 2014). Therefore, this literature search reveals there is still room for qualitative methods to further define APRN transitions in novel settings.

Table 3

Systematic Review Table

QUANTITATIVE STUDIES/MIXED METHODS					
REFERENCE	PURPOSE	SAMPLE & SETTING	DESIGN/TOOLS	MAJOR FINDINGS	IMPLICATIONS
Barnes, 2015	Examined the relationship between NP role transition, prior RN experience and formal orientation	Descriptive cross-sectional survey 352 NPs @ a national NP conference	Nurse Practitioner Role Transition Scale (NPRTS)- 5 pt. Likert scale	Formal orientation to PR role transition- B=6.24, p-.000 Prior RN Experience B= -.01, p- .12	Only orientation contributed significantly to positive relationship with NP role transition
Horner, 2017	Determine whether mentoring based on Watson's caring model positively influenced nurse practitioner job satisfaction	Mixed Methods-Convenience sample NPs from large urban health care setting. N-37 (56% response) Free text responses	MNPJSS-Misener Nurse Practitioner Job Satisfaction Scale Reliability-Cronbach's a=.96 Free Text Survey	72.97% reported not having a mentor upon hire as an NP	100% of those with mentor reported the experience as positively influencing job satisfaction. Intrinsic factors (subscales) were most highly associated with job satisfaction Extrinsic factors (subscales) were least associated with job satisfaction

Table 3, continued

Hart, 2016	Assess new NP perceptions of teir preparation for and transition into clinical practice	Mixed Methods 698 NP Retrospective Survey Qualitative content analysis		Satisfaction with support accounted for 42.5% of variance (a-0.91) F=36.145, p<.00 in preparedness to practice. Feelings of preparedness accounted for 29.3% of variance (a-0.80) f=86.67, p,.00	Only 3.3% of respondents reported being very well prepared for practice after education. 19.8%+42.8%= 62.6% felt adequate support was provided during the 1st year transition to clinical practice. 50% of respondents wrote new NPs need help transitioning to practice 49% responded they felt they practiced beyond their level of competence in year 1

Table 3, continued

Faraz, 2017	Identify factors associated with successful transition and turnover intention in first year of NP Practice in Primary Care	Descriptive Cross-sectional design Convenience sample N= 207	Modified Social Support Questionnaire Short Version Role Ambiguity Scale (RAS) Confidence Scale (CS) Misener Nurse Practitioner Job Satisfaction Scale (MNPJSS) Anticipated Turnover Scale	Professional autonomy significant predictor of turnover intention b=-.63, p<.001 explaining 40% of variance. Quality of professional and interpersonal relationships did not add significantly to turnover intention B=-.12, p=.32. When all 3 variables added, Professional autonomy (b=-.44, p=.001) and role ambiguity (B=-.20, p=.03) to turn over intention, accounting for 48% of variance in turnover intention. Validity established-moderate effect size, 80% power, 5% significance level	Professional autonomy to turnover intention p=.001 and role ambiguity p=.03, accounting for 48% of variance in turnover intention.

Table 3, continued

Dillon, Dolansky, Casey & Kelley, 2016	Examine the relationship among personal resources, community resources, successful transition and job retention.	Descriptive Correlational 592 NPs	Modified Casey-Fink Graduate NP Experience Survey Validation-content validity	46% reported experiencing stress Top 2 stressors were job performance and financial stress Statistically significant correlations between Organizational support and : Comfort/confidence r=.049, p<.01 Patient safety r=0.38, p<.05 Professional satisfaction p=0.72, p<.05 Job satisfaction (r=0.53, p<.01 Significant relationship between communication/leadership and job retention (r=-0.35. P<.05)	Community resources of organizational support and communication.leadership were related to successful transition (comfort/confidence, patient safety, and professional and job satisfaction) NO relationships were found between personal resources and successful transition.

Table 3, continued

MacKay, Glynn, McVey & Rissmiller, 2017	What are the perceptions of practicing NPs regarding NP residency programs as a strategy for transitioning to practice 2) What content do practicing NPs identify as important in a successful NP residency program?	Exploratory descriptive mixed methods 12- questions Likert sacle evaluating NPs perspective on their own experience as a novice NP Open-ended questions content analysis 159 NPs from various settings	Clinical Teaching Effectiveness Instrument (CTEI) Reliability a=.97 2 additional test items a-=.97 Open-ended questions	50% reported the first year was difficult and felt unprepared. 86% saw value and benefit to an NP residency program for future practitioners. 80% would have been interested in a residency program Content analysis revealed that NPs are least prepared during their transition for independent decision making, time management, complex care, prescribing, interdisciplinary communication, minor office procedure, and billing/coding.	Great number of NPs expressed desire to have NP transition programs for future NPs. Lack of mentoring was difficult due to critical decision making with complex patients. Lack of communication with interdisciplinary team and specialists was identified as a challenge during transition. Billing/coding seen as a necessary addition to any residency program

Table 3, continued

QUALITATIVE STUDIES					
Reference	Purpose	Sample	Method/Theoretical Framework	Outcomes/Themes	Significant Findings
Rugen, Harada, Harringont, Dolansky & Bowen, 2018	Descriptive perceptions of their strengths, areas for inmprovement and goals while participating in an NP residency program in the VA	38 NP residents	Qualitative descriptive, content analysis Survey given at 1 month, 6 months and 12 months. Expectancy-value theory	8 Domains graphed via frequency over time Clinical competence Leadership competence Interprofessional Collaboration Patient-centered Care Shared decision-making Sustained relationships Performance improvement Professional Development	• Demonstrates that NPs perceive advancement in their competency over time • In early practice they rate basic clinical skills more highly • As progress to the 12 month marker, perceive are better at more complex skills like chronic disease management and focus on more global skills such as clinical reasoning and complex care. • Long-term goals and short term goals identified as clinical and professional development • Short term goals evolved over time to focus on more systems-level concepts such as QI and teams • Gaps noted in residency in regards to leadership and performance improvement

Table 3, continued

Pop, 2017	Develop a theory of mentoring for new NPs in a hospital setting	Purposive Sampling shifting to theoretical. NP- 8 mentors, 8 mentees in a NP transition program in a hospital setting Semi-structured interviews	Grounded Theory Humanistic Nursing Theory	1 Core category Defining Self and 3 main categories which represent the 3 main phases of the mentoring process. Forming the Relationship Developing the relationship Mentoring Outcomes	Well designed and implemented formal mentoring programs assist NPS new to the profession as well as new to an organization. Theory developed, recommends testing this theory in various settings.
Owens, 2018	Explored perceptions of experiences while transitioning to NP identifies in first year of primary care practice in rural healthcare settings.	10 NP in rural healthcare settings during 1st year of transition Longitudinal approach over 1 year. Present and retrospective	Phenomenology	Learning New Skills, Knowledge and Roles Interactions and relatinoships with patients, nursing staff and providers Desire to practice in rural health Role transition to NP professional identity Professional Identity and work satisfaction	Participants expressed transition through school and through first year of transition Expressed feelings of role diffusion and lack of anonymity, being a generalist, having autonomy, experiencing trustful relationships with patients, nursing staff and other providers- Consistent with previous research into rural nursing. Mentoring provided support and facilitated their transitions

Table 3, continued

Sullivan-Bentz, Hubert, Cragg, Legault, Laflamme, Baily & Doucette, 2010	To examine role transition and support requirements for NP graduates in their first year of practice from the perspective of NPs and coparticipants familiar with NP practice.	23 NP graduates and 21 coparticipants (MD, NP, managers) in primary care setting Canada	Descriptive qualitative informed by focused ethnography and narrative analysis In-depth, semistructured interviews	5 themes identified: Transition to NP role Contextual factors affecting NP transition Interprofessional relationships Provincial policies and politics Educational preparation	It is important that when hiring a newly graduated NP, the administrators, physicians and staff understand how NPs can work effectively within the primary healthcare team Poor understanding of the NP role and professional territoriality are barriers to integration of NP role Interprofessional education is needed as unfamiliarity with the NP role created challenges for both groups Policies created competition between the groups for certain procedures leading to care based on billing opportunities rather than client care.

Table 3, continued

Elliott, Walden, Young, Symes & Fredland, 2017	To describe the lived experiences of NPs practicing within the Transformational Advanced Professional Practice Model PPM)	11 NPs in hospital and ambulatory care center in Houston Tx	Phenomenology Transformational Advanced Professional Practice Model	Transforming professional practice (allowed for a specific framework within which to base day-to-day professional practice) Cultivating the Inner Self (model allowed for explicit recognition of internalized self that drives passion for NP work) Mentoring professional transitions (saw potential to use the TAPP Model as guide during transition for new NPs as organizational support was viewed as important in transition from RN to NP)	NPs actively used components of the model to guide care delivery and professional activities The TAPP model allowed participants to articulate their inner self and intrinsic drive to NP practice and allowed participants to feel fulfilled in their service to others as an NP Professional development and mentorship are inextricably interwoven.

Chapter 3: Methods

Introduction

This chapter will provide an overview of Ethnographic Qualitative Methodology and relevance to the issue of APRN transition. It will begin with a description of Ethnographic Methodology in general and how it is a useful method to understand a complex system and process of APRN transition to practice in the first year in a LTC environment. Descriptions of the research project design, sampling, procedures, and analysis will complete this chapter. Overall, it is the position of this author that ethnographic methods are ideal for exploring an unknown phenomenon, APRN transition into LTC settings. Through embedded observations and interviews, I can work in an iterative fashion to interpret how the culture and setting influences APRN transition, and in turn, how the APRN presence influences the culture of the LTC.

Ethnography Overview

Ethnographic methodology allows the researcher to use a constructivist- and interpretivist paradigm to understand interactions in a social setting (Durdella, 2019). By placing oneself in a cultural and social setting, the researcher has the power to observe the mundane and the extraordinary to understand how a system functions. With CS as the sensitizing framework, ethnography is a natural methodology to create a holistic description of subjects and an explanation of patterns that emerge from a social and cultural life (Agar, 2004; Durdella, 2019). Ethnography finds its research tradition roots in anthropology and sociology to understand cultural experiences to learn how a group behaves and produces meaning or systems (Rock, 2010; Durdella, 2019). Ontologically, ethnography allows for understanding how reality is constructed, and creates an epistemology for how to set about learning about this reality through symbolic interactionism (Rock, 2010; Durdella, 2019). The individual's reality emerges through

actions and narration that reveal how they interpret and make sense of the world (Rock, 2010). Therefore, the reality constructed is interactionist as it is based on how the individual acts upon their understanding of the world, which then in turn acts upon the individual through this created meaning (Rock, 2010).

As APRNs transition into practice, they naturally must go through this experience within the cultural context of the organization to which they are assigned. It is illogical to reduce the unit of analysis to the APRN herself or to the organization structure only, as the transition experience is found where the components intersect, communicate, and a new cultural reality with created meaning. Through descriptive representation, the researcher can learn from the environment among the subjects of interest, in order to ascribe meaning to the regular behaviors that indicate cultural importance and therefore meaning (Durdella, 2019). Description of meaning is emphasized so the researcher must enter the field as a participant-observer to build relationships, trust and engage in interpretation of the system observed (Durdella, 2019). The researcher herself will also be interactive and interpretive with her own "world of meanings, symbols and motives" which must be acknowledged (Rock, 2010, p. 30). Culture is a process through which meaning is continually renegotiated by it's participants into new understandings and action, including the researcher who must construct meaning and is the primary narrator of this process (Van Maanan, 2010).

Again, these paradigms lend themselves naturally to the framework of CS as ethnography focuses on understanding systems and the culture created through mutually interacting relations (Turner & Baker, 2019). The components of the system are secondary, and it is the relationship between them that is dominant (Braithwaite et al., 2018). The interactionist approach allows the observer researcher to identify interaction and connections to elucidate the emergence of a CAS

in a non-linear fashion (Turner & Baker, 2019). Human actions take place in a situation that "confronts the actor" and that the actions of that actor are defined by the situation; in other words, the actor symbolically interacts with their environment through their understanding of the situation (Rock, 2010, p. 27). As the APRNs learn and begin to understand themselves in a symbolic healthcare world, they will be transformed through their interpretations and understanding of themselves as CAS and an adaptive symbol which will in turn influence their environment. By observing the emergence of thoughts and actions, the researcher will gain insight into the co-created world the APRNs inhabit and the co-created transition experience of the APRN as a CAS. Constant "interaction between mind and its environment" is the element of analysis, not the reduction to "initial conditions" (Rock, 2010, p. 28).

Dan-Cohen (2017) does caution though, that the use of complexity to frame the ontological approach to anthropology threatens to create its own complexity by sensitizing all cultural understandings as complex. The risk with approaching anthropologic observations, including ethnography, with a complex lens is to dismiss the simple and reductionist approach of linear inquiry as naturally lesser-than and to elevate the ideas of complexity as superior. This will only create a false understanding of all knowledge as complex and irreducible and create "complexity as an end-in-itself and diagnosis" instead of a holistic understanding of a culture (Dan-Cohen, 2017, p. 287). Instead, this study will work to find thought and interactionism as emergent instead of breaking down features of the observed world to its "initial conditions" while remaining sensitive to the caution of Dan-Cohen not to overlook the reducible and observable elements of transition (Rock, 2010, p. 28; Dan-Cohen, 2017). Treating the APRN as a CAS as well as the system within which they transition as a CAS, understanding will come from interpretation and of how thoughts and actions are situated within a culture and social context.

In order to obtain authenticity and increase validity, the researcher should employ both interviews and observations to obtain multiple viewpoints (Durdella, 2019). Observations happen in naturalistic settings, while recorded interviews naturally must occur in a more formal setting. Observations are focused on what the observer sees, hears and smells, which is more than what "appears in sight" and is subject to the perspective of the researcher as interpreter (Durdella, 2019, p. 238). In ethnography, researchers are not passive but instead are "interactive, creative, selective, interpretive" tools which "illuminate… further paths of inquiry" (Rock, 2010, p. 30). Placement of the researcher in the work setting as a participant observer allows for an immersive experience and access to observational data that is not attainable through other methods (Smith, 2010). Importance is placed on the knowledge that the actors in a system use to guide actions and synthesize meaning from everyday life. Interviews are informed by the participant observations and are therefore conducted in-context to reveal how subjects interpret and assign meaning to situations. Narrative is recognized as one of the major ways in which humans organize their understanding of the world and to make sense from experience (Cortazzi, 2010). However, it must also be acknowledged that narratives in scheduled interviews are necessarily used to convey intention and motive of the speaker and may differ from the message delivered in everyday conversation. Therefore, observation and interviews are synergistic for the researcher in developing themes and analysis (Cortazzi, 2010). The interaction of the ethnographer as participant allows for evolution through "knowledge about others' knowledge" and for the continual, iterative interpretation and evolution of repeated subject interviews (Rock, 2010, p. 31; Smith, 2010).

Rich descriptions are a form of validity which create a vivid description of the system in question and offer multiple perspectives to "transport (the) reader(s) to the setting" (Creswell,

2014, p. 202). The observer uses imagery and recall of descriptive fieldwork in an impressionist tale to provoke interpretations which the author then proceeds to "address and assess" (Van Maanen, 2011, p.107). It is also important for the observer to create validity by checking accuracy through not only her own standpoint, but also through the standpoint of all participants in the environment (Creswell, 2014). Trustworthiness and authenticity are created when the observer triangulates different data sources to ensure accuracy, but also uses member checking to review preliminary interpretations with the participants (Creswell, 2014). The researcher can also create reliability through participation in a certain level of "confessional tale", revealing their analysis process which is dependent on "second-order, textualized, fieldworker-dependent version(s) of the event" (Van Maanen, 2011, p. 95). Reflexivity is a necessary step in ethnography as the author positions, navigates and interprets their subjects with acknowledgement of how unconscious bias, prejudices and power imbalances may influence observations and interpretation of ethnographic understandings (Benson & O'Reilly, 2020).

Reflexivity is an expected feature of any ethical qualitative researcher, allowing the researcher to acknowledge their unique perspective and recognize how interactions with subjects co-creates a community and culture (Guillemin & Gillam, 2004; May & Perry, 2017). Semi-structured interviews allow deeper understanding above observations and also allow for triangulation to further verify findings (Durdella, 2019). Interviews are best performed in a semi-structured manner to allow for understanding derived from observations to guide further probing questions (Durdella, 2019). Though interviews can occur separate from observations, especially if observations are prohibitive, they work in concert to better understand complex cultural systems and their outcomes (Durdella, 2019).

Research Design

Ethnographic methodology is particularly well-suited for examining system inter-relationships in order to understand the transition experience of APRNs into their first year of practice in a new setting, the LTC. For this research study, I employed ethnographic observations and semi-structured interviews to help understand context and cultural experience of transitioning into an LTC. IRB approval was granted by the University of Texas at Austin prior to data collection. Analysis took place in the classroom onboarding setting, as well as 5 different LTC settings with 9 APRNs. Observations and interviews were used to triangulate findings, and periodic check-backs were utilized with participants to validate findings. The participants of interest are the APRNs but also administrators, nurses and aides in the LTC settings. By elucidating multiple viewpoints, I was able to create a rich description of the transition experience to help illuminate the needs and challenges APRNs experience during this time of insecurity. Cross-site findings were considered to create a holistic yet tailored picture of APRN transition that emerged from narratives, actions, interviews, and observations.

An *a priori* sensitizing framework of CS and operational model (See Fig.2) were helpful to guide both data collection and assist with analysis. The semi-structured interview approach was informed by the literature re: nursing transition, yet ethnographic methodology is iterative in nature, so I adapted observation timeframes and interview questions as needed throughout the study.

Research Questions

AIM 1: What are the experiences of APRNs as they transition into a new practice environment in the LTC setting?

RQ1.1- How does the practice environment influence the APRN transition?

RQ1.2- How does the APRN presence transform the practice environment?

Setting

Observations occurred first in a classroom setting as APRNs attend onboarding classes at a local University. Interviews began immediately in the classroom in an informal setting with semi-structured questions and continued in an iterative fashion throughout the APRN transition period and the period of the study, approximately 1 year. Observations were made in the LTC facilities where APRNs were placed to provide care. These facilities are in the Central Texas region and agreed to a pilot project wherein APRNs are employed to work directly with the facility to see residents and oversee quality improvement initiatives and data collection. Interviews were revised in an iterative fashion and continued periodically throughout the observation period in the LTC setting. Once the COVID-19 pandemic necessitated isolation procedures in the LTC setting, beginning in March of 2020, in person visits and interviews were no longer accessible, so the interviews continued online via Zoom© platform.

Sample/ Sample size

Purposive sampling was used and all APRNs in the study were included in the sample of interest (n=9). Ethnographic observations continued for the entirety of the one-year project, which coincides with the greatest insecurity in APRN transition to practice as identified by the literature review (See Chapter 2). Interviews occurred as needed to illuminate findings from observations and as needed to circle-back to participants to verify findings. I maintained close consultation with an academic advisor before and throughout the project to discuss and further process understandings and challenge findings. The benefit to society is the potential understanding of the unique challenges APRNs face transitioning to practice in the LTC environment, which is historically underserved by providers. Thematic analysis and synthesis of

ethnographic observations and interview data were carried out in an ongoing and iterative fashion to further understanding of potential best-practices for APRN transition into the LTC setting.

Table 4

Sample Inclusion/Exclusion

Inclusion	**Exclusion**
APRN LTC Administrators (CEO, DON) RN LVN Nursing Assistive Personnel (NAP)	LTC residents Resident's families
All shifts- Day, Night or Evening	None
Employed Full or Part-time, PRN or traveling nurses	None
Long-Term Care Settings	Community Settings, Public Health Settings, Adult Acute Care, Operative, and Inpatient Settings
English Speaking (even if not primary language outside of hospital unit environment)	Non-English Speaking

Recruitment

Recruitment occurred through the UT School of Nursing, Center for Excellence in Aging Services and Long Term Care (CEASLTC) APRN study, "Transition to Practice in Long Term Care Setting in Texas, a Collaborative Quality Improvement Project" in collaboration with Texas Health and Human Services Commission (TXHHS). All nine APRNs assigned to this quality improvement pilot project were included for observations and interviews, as were LTC Administrators, and a purposive sampling of RNs, Medical Directors (MD), and aids (CAN) in the LTC setting. IRB approval was obtained through the University of Texas at Austin. Purposive sampling was used to identify participants that met the inclusion/exclusion criteria for observations in the LTC settings including Medical Directors, Administrators, and nurses.

Procedure

During the first two months, I observed APRN participants in the classroom onboarding environment. During months 3-8, I then performed on-site observations in the LTC setting, including opportunistic semi-structured interviews with APRNs, LTC administrators and a purposive sampling of MDs, RNs/LVNs and CNAs. Field notes and journaling were used in an iterative process to further inform future observations and interviews. Select interviews were recorded and transcripts generated for analysis. Unfortunately, the COVID pandemic forced an end to in-person observations during Month 9 of the first year due to quarantine and isolation procedures, especially in vulnerable LTC populations. However, interviews continued throughout the entire 12-month observation period using at first in an person modality and after quarantine, an online platform via videoconferencing (Zoom©). Triangulation and check-back methods were used to ensure credibility/trustworthiness of previous findings and analysis was reviewed with the academic advisor on a regular basis. Along with interviews, I used journaling to inform the iterative process, to demonstrate trustworthiness in the interview process through revised questions informed from observations and previous interviews. Interviews and observations continued until the APRNs either left the project or reached the one-year point of their transition, at which point the application phase of the grant was completed and the APRNs were no longer practicing within the LTC facilities.

Research Protocol

Observations continued throughout the entirety of the transition period which was approximately 1 year (July through June). As the interviews were iterative, interviews were reformulated continuously throughout the data collection process as informed by previous interview findings and observational findings. Based on initial responses, interview questions

were revised, and participants were contacted for follow-up focused interviews. Check-back with participants helped to ensure trustworthiness, as well as triangulation between interviews and observations.

Privacy and Confidentiality

Participation was voluntary. Participant identifying information was not collected, and the researcher used aliases for all study participants in this manuscript. All findings were anonymously coded for analysis and reporting. All data were collected electronically including field notes, journals and recorded interviews. The UTBox secure management system, licensed by The University of Texas at Austin (UT Austin), was used to for data storage (http://www.utexas.edu/its/survey/). This system is approved by the UT Austin Information Security Office (http://security.utexas.edu/) for collection and storage of the type of research data collected for this study. UTBox cloud storage is also approved by UT Austin for category 1 data and was used for secure data storage and collaboration between the researcher and academic advisor (https://www.utexas.edu/its/cloudstorage/).

Data Collection:

Ethnographic Observations

Observations occurred in the classroom onboarding environment for the first 2 months before moving into the partnered 5 LTC settings. Observations focused on environment, culture and interactions between participants and the organizational atmosphere. As Spradley (1980) states, ethnographers study culture through “three fundamental aspects of human experience: what people do, what people know, and the things people make and use” (p. 5) Observations were planned to continue for the period of 1 year until the completion of the quality improvement pilot, however the COVID-19 pandemic necessitated an end to observations after 9

months. I was no longer able to gain access to LTC settings for observations, so the focus necessarily shifted to interviews and further interpretation/analysis.

Ethnographic Interviews

Interviews were performed with the 9 APRNs as well as LTC administrators and MDs. Semi-structured interviews were used to interview participants in both naturalistic and pre-arranged settings. In ethnographic research, data analysis occurs concurrently with data collection in an iterative process, so the interview process and questions necessarily evolved throughout the course of the study (Durdella, 2019). Spradley (1979) identifies 5 steps to analyzing ethnographic interviews that occur simultaneously giving constant feedback to both the collection and the analysis: 1) Selecting a problem, 2) formulating hypotheses, 3) collecting data, 4) analyzing the data, and 5) writing up the results. Some questions occurred spontaneously in the course of observations, but intentional, recorded questioning was also used. After interviews began, I developed additional questions informed by observations and previous interviews to meet the study specific aim of understanding the transition experience of APRNs in the LTC setting. Questions were focused on the daily as well as the special incidents that occurred during this transition, focused on the minutiae as well as the larger picture (Durdella, 2019). Interviews continued until I uncovered all potential themes and the study ended at year 1. Select interviews were recorded and transcribed for review.

Sample questions:

Demographic.

Age, gender, ethnicity, years of nursing education, and years of nursing experience (RN and APRN)

Ethnographic Guiding Questions

- How is your transition going?
- How has the organizational culture influenced your transition to practice?
- Please describe your story of how the facility either helped or hurt your ability to fulfill your role as an APRN?
- Please describe how you feel during this transition period?
- What impact do you believe you have had on the culture of the facility?
- What impact have the APRNs had on the culture of your facility?
- How are the APRNs fitting in culturally at your facility?
- How has your relationship with the study APRNs evolved?

Journaling

To ensure trustworthiness, I kept a journal to allow for processing and data analysis to occur in a timely and iterative manner. These notes differ from the observational notes in that they focused on my thought processes and learnings from observations in order to lend validity and increase confidence in the findings (Miles et al., 2014). Reflexive thoughts and interpretation were carefully recorded to make the process clear and shared routinely with the academic advisor for challenge and feedback.

Data Analysis

Content, field notes, interview transcripts, and journal entries, were analyzed and systematically organized into broad categories describing the phenomena of interest throughout the collection and analysis phases. Information and explanatory patterns were derived through analysis of all written and recorded notes, interviews, and investigator journals for meaning. As the goal of this ethnography is to understand the influence of culture on the APRN transition,

care was be given to focus on attractors that alter the trajectory or the APRN transition and CAS emergence. Rich descriptions were used to tell the story of the APRN transition, including as many cultural influences as possible to influence this experience.

Data analysis was iterative, with processing occurring as observations and interviews were ongoing. Interview questions were adapted as needed and analysis of data continued until an understanding of the first year APRN transition was reached, and the study completed at date year one. Occasional check-backs with the participants from the study allowed for validity of findings as the identified themes were approved by the participants (Durdella, 2019).

Ethics in Practice/Trustworthiness

Relationships

Developing rapport with subjects allows for engagement, understanding and empathy on the part of the ethnographer (Jackson, 2021). This in turn opens up lines of communication and allows for interaction that contributes to deeper understanding and interpretation of ethnographic findings and contributes to rigor (Jackson, 2021). Spradley (1979) identifies four stages to successful rapport establishment, that can happen in both the interview process as well as participant observations, which I considered when planning and advancing subject relationships: apprehension, exploration, cooperation, and participation. Likewise, when the COVID-19 pandemic caused many outbreaks and deaths in LTC facilities across the nation and the world, the embedded APRNs expressed stress and concern for their safety as well as the safety of their residents. Thankfully both time and interactions had allowed for development of rapport to the participation stage which encouraged the APRNs to share and disclose concerns they may not have earlier in the rapport development process.

As both an ethnographer researcher, and a graduate research assistant on a study involving the same population, it was necessary for me to consider and negotiate any perceived conflicts of interest. Power dynamics are always a concern and can lead to unequal relationships between the researcher and the subject; however, establishing rapport as women and nursing professionals with a shared education was one way to help lessen, if not overcome, this gap (Oakley, 1981; Doucet & Mauthner, 2008; Ochieng, 2010). When participants wanted to share understandings or probe into my own experiences, I judiciously shared my own transition stories in order to create interactionism and shared meanings. Again, this process was aided by a shared educational backgrounds and knowledge of the TXHHS APRN study goals helped create "reciprocity" and likeness that might not have been possible if the researcher was from a completely different background (Couture et al., 2012; Skeggs, 2002). Even with these shared backgrounds, I was sure to approach the study as a learner with the "frame of mind" to "set aside assumptions" and focus on respondents intended meaning and the meaning of shared experiences (Glesne, 2015, p. 134).

Trustworthiness/Credibility/Reflexivity

Trustworthiness was addressed through the use of journaling, in collection as well as analysis. Reflexive journaling was used to examine my own position in relation to the subjects, actively learning and revising the study approach. As ethnography is a social endeavor, it is vital for the researcher to address their own consciousness and how their interpretations of the shared experiences necessarily affects and is affected by those experiences (Lunsden, 2013; Benson & O'Reilly, 2020). Journaling and frequent discussions of the research progression with an academic advisor helped me to be reactive and responsive to the findings as they emerged and were interpreted, increasing credibility.

Guillemin and Gillam (2004) differentiate between formal "procedural ethics" such as an institutional review board review, versus "microethics" or "ethics in practice" that arise as potential conflicts through the interactions between researcher and participants, such as establishing trust and deciding how much to disclose to participants about findings in an iterative process (p. 265-266). Reflexivity is a way for the qualitative researcher to address ethical concerns through acknowledging and being sensitive to these microethical issues that may arise during the course of a study (Guillemin & Gillam, 2004). To address these concerns, I conscientiously considered any ethical conflicts that did arise through day-to-day interactions through journaling and discussions with an experienced academic advisor, and incorporated discoveries into adjusted interviews and observation techniques; this allowed me to ensure the qualitative approach was credible and the results obtained and used for revision were trustworthy through a clear audit trail.

Summary

This ethnographic research, grounded in CS and CAS, is designed to examine the experience of APRNs through the first year as they transition into a new practice setting, the LTC. Observations occurred of all APRNs and LTC administrators already participating in a quality improvement pilot program in the Central Texas region as well as a purposive sampling of individuals working in the LTC setting. I interviewed APRNs and LTC administrators as well as a purposive sample of LTC employees meeting the inclusion criteria. An iterative process was employed to adapt interview techniques and questions as needed to capture the intended phenomena of interest. Trustworthiness was reinforced through journaling and check-backs with participants as themes were uncovered and preliminary results were discussed throughout with

an academic advisor. Data collection continued until the ARPN transition period concluded at year one.

Chapter 4: An ethnographic account of APRN transition to practice in LTC

Findings

"Ethnographic work is not always orderly. It involves serendipity, creativity, being in the right place at the right or wrong time, a lot of hard work, and old-fashioned luck" (Fetterman, 1989, p.12).

This chapter will draw attention to the APRN transition as they entered into practice in their respective LTC environments using ethnographic descriptive methods. Through the stories of Alison, Charlotte, Kelsey, Carrie, Victoria, Sally, Jenny, Natalie, and Donna, the reader will be shown the effects of institutional acceptance, practitioner competition and the struggle for practitioner legitimacy on the ability to fully transition into their expected roles. From here the researcher will identify the role of practitioner preparation and expectations of job performance on the APRN's ability to realize their roles as individual and organizational care provider. Participants will be referred to by pseudonyms to protect their identities. Quotations from transcribed in person and zoom interviews, as well as from recorded observations, will be used to illustrate and emphasize findings (in italics).

Sample

Nine APRNs were chosen as part of a Texas Health and Human Services Commission (TXHHS), Civil Money Penalty (CMP) grant in collaboration with the Center for Excellence in Long Term Care (CEASLTC) at University of Texas at Austin School of Nursing, which sought to embed APRNs within LTC facilities to "determine if employment of a full-time, salaried APRN, as part of the NF care team, reduced the rates of adverse events and improves quality of

care for NF residents (Interagency Cooperation Contract, 2017, p. 5). TXHHS recruited 5 LTC facilities in the Southwest United States region, including securing the agreement of their associated Medical Directors to provide APRN oversight which is required in the state of practice. Three of the facilities were traditional nursing homes, one was a combination nursing home and acute rehabilitation facility, and the last facility focused on long term care of residents with psychiatric comorbidities. CEASLTC was responsible for hiring and personnel management through the duration of the study including APRN orientation, training, and quarterly conference calls to monitor progress on the project, as well as technical assistance to facilities as needed. As part of this collaborative study, I conducted qualitative, ethnographic observations & interviews for the duration of the grant period, approximately 1 year.

The level of LTC experience for these APRNs varied greatly, with seven having no experience in this environment, and the two with experience ranged from two to10 years (though the APRN with 10 years had experience in the LTC at the RN level, not advanced practice). Five of the APRNS were new to practice at an advanced practice level, with one being a 2nd degree student (e.g. alternate entry into a nursing program at the master's level) having no previous RN-level experience. The remaining three APRNS, with previous experience in settings other than LTC, ranged from two to five years of advanced- practice experience (with the one mentioned previously having 10 years of LTC experience at the RN level).

Findings

The findings of this study are represented by five major themes that influence APRN transition to practice. Table 3 provides the breakdown of categories, sub-themes and themes created from the interpretation of all available data. The overall finding of this study was the

environment, both physical and cultural, as well as the intrinsic factors, all played a role in how APRNs experience transition to practice.

Table 5

Categories, Sub-themes, and Themes.

Category	Sub-Theme	Theme
overwhelmed, anxious "trial by fire", "drink from the hose" "excited to start"	Orienting to role expectations	Legitimacy as Provider
Demonstrating Nursing Skills Recruiting staff as early promotors of their role	Proving Oneself	
Facility layout Provider Space Institutional Mission	Hospitable Environment	Institutional Acceptance
Interactions with administrators	Personnel Welcome	
"I'm confident, I'm smart" Meeting self-expectations	Intrinsic Factors	Personal Role Fulfillment
Nurse Practitioner cooperation/communication Medical Director support	Provider competition	Provider Relationships
Preference for patient care Discomfort with billing Discomfort with quality improvement	Role Confusion	Individual vs. Organizational Caretaker

Theme 1: Establishing Legitimacy

At the beginning our interactions and rapport formation, I realized quickly that the APRNs were in a state of awe and analysis paralysis that was also tempered by excitement of beginning a new role. Sub-themes were identified by observation and interviews which emerged from reflection of categories including; orienting to role expectations and proving oneself.

Orientating to the role expectations: Overwhelmed, "Drinking from the Hose", "Excited to Start"

I was introduced to these APRNs during their onboarding experience, which included 8 weeks of full-time classroom instruction focusing on regulatory and quality training. My entre' into their world came through introductions by my advisor, who was also in charge of the APRN personnel decisions; providing me both status as a fellow researcher, but also creating a perceived barrier I needed to negotiate to gain acceptance and candid rapport with each APRN as a *nurse* and not as a spy for administration. I would use our shared experiences as nurses many times over the following year to both engender trust through shared knowledge of training and job experiences, but also to create shared understand with the APRNs- a technique I also noticed the APRNs using in the field to accomplish trust and relate to the first theme of *establishing legitimacy* as a nurse in their respective facilities. But before they could enter the facilities, the APRNs would experience classroom onboarding and a chance to establish their bona fides as practitioners in an LTC facility.

In class, my standing as a graduate student immediately intrigued Jenny, who had graduate research experience, and she immediately took me into her confidences. "*These guys are drinking from a water hose*" causing a "*catatonic*" response to the "*avalanche*" of information covered, she said referring to the inexperienced APRNs. Though she had little experience in the LTC environment, Jenny confided that she "*gets*" the regulatory world and that the new nurses will have to "*live it"* to understand it. Donna was an APRN with a confident demeanor who had experience running an NP clinic in another state and had experience and responsibility functioning as an APRN within a regulatory environment. Even with her years of experience, Donna explained the regulatory environment for Texas was "*a bit overwhelming*"

and she would have to "*continue to absorb*" information through classes. Carrie, another experienced APRN was calm and measured in her questions and had the most relevant and frequent questions for the presenters. Natalie, one of the APRNs with no previous experience at the advanced practice level did not ask any questions during the presentation but afterwards expressed excitement saying, "*we all just want to get out there*".

As I sat in on their classroom experiences, I noted that the APRNs reacted very differently to the material presented, which usually reflected their level of experience. The most experienced APRNs seemed to congregate on one side of the room and the newer APRNs with less or no experience congregated on the other. When asked about this seeming division, Jenny was dismissive of it being meaningful and said, "*we just get along that way*". Participation in the class depended on material and presentation with some better received than others. The usual presentation consisted of a presenter at a lectern proceeding through a PowerPoint slide deck, while the APRNs attended mostly to their laptops with occasional side conversations. The ones most likely to ask questions were the experienced APRNs while the new ones sat quietly more engaged in their laptops than the presentation. When I asked Alison about her quietness during and after presentations, she said she was just "*absorbing information*" and Natalie added they felt "*bogged down*" with classroom activities. Alison also confided insecurity over her as of yet undecided placement and being "*excited but nervous*" about entering a new area of practice, even though she had advanced practice experience in a busy acute care environment.

Overall, it appeared that the more experienced APRNs knew what questions to ask, but the less experiences APRNs did not know what they did not know, reinforcing what Jenny had told me; "*they will have to live it to get it*". Towards the end of the year, Charlotte added

"*training would have been more beneficial if I went to the facility first*", and "*it was a little too much, a little too quick*".

Our last classroom experience together occurred on a day originally planned for a "meet and greet" with the directors of their newly assigned LTCs. The presentation had been rescheduled at the last minute giving the APRNs an unexpected afternoon off, and no set rescheduled date had been planned for either the meet and greet or the official start date in their respective facilities. The APRNs had been given their "assignments" earlier in the week, which paired them in an attempt to match experienced and inexperienced APRNs together for support, and this was reflected in a different seating arrangement than I had seen before. Most, but not all, of the pairs had chosen to sit together for this last presentation. The atmosphere in the classroom that morning was a strange mix of fatigue and excitement, ne' anticipation causing disconnection. The uncertainty of the official start date and the unknown rescheduled date for the meet and greet left many feeling further anxiety and unusually distracted. During classroom breaks the conversation was focused on what the APRNs would do with their unexpected days off with no mention of their impending entry into the workplace. After class, I had trouble catching any of the APRNs because they were all focused on heading out quickly for the weekend. Jenny was friendly but distracted in our conversation stating she was anxious to "just start already" and was nervous about being paired with an APRN with no experience. Her partner was Natalie and prior to today, these two sat in different areas of the classroom and I had not seen them interact. Jenny was hopeful for their partnership but reinforced what she had said before; that due to inexperience, Natalie was going to experience "*trial by fire*" and would spend her first few months "*under water*".

Proving Oneself: Demonstrating Nursing Skills, Recruiting staff as early promotors.

After placement in the five selected long-term care facilities, I visited all the APRNs in their respective facilities and conducted interviews focused on the aim and research questions. Each facility had its own culture that influenced how the APRNs were able to function and experience their respective transition, during this time some patterns were seen across the sample. Based on my observations that the nurses were mostly out and about interacting with others when I visited vs. in an office, I iteratively began to ask the nurses what they did to help establish themselves as practitioners in their settings. Charlotte related what most APRNs reported, in that they resorted to basic nursing skills in the very beginning to identify themselves to everyone in their respective facilities as a "*nurse*" first and foremost. The newer APRNs were more reliant upon this technique, but it was tempered if they were paired with an APRN who had more advanced nursing experience. For example, Victoria and Alison were paired together and neither had LTC experience, and they both reported turning, feeding, and ambulating residents in the beginning. They experienced insecurity in their roles and Victoria especially reported more comfort with hands-on patient care than rounding and order writing. In contrast, Donna and Sally who had collectively over 10 years of advanced practice experience did rely on basic skills to "*be helpful*" but their primary focus was on establishing teamwork, not to establish their legitimacy. When I relayed Victoria and Alison's reliance on basic RN-level nursing skills to try to position themselves amongst the staff at their facility, Sally raised her eyebrows in a dismissive way and Donna, in her very kind a patient way, said "well that might work for them". When I asked Charlotte why she was bathing and turning residents as this wasn't usually an advanced practice role, she stated "*someone had to do it*" but also relayed it was hard to accomplish her initial patient assessments (which was her actual advanced practice responsibility) because she was so

busy "*filling in for the CA* (clinical assistants)". When pressed for why she continued to perform these basic skills if it interfered with her APRN charge, again she said "*they appreciate the help*".

The APRNs benefitted twofold from applying basic nursing skills in the beginning, because they established themselves as caretakers embedded in the facility, and they also engendered goodwill amongst the staff. Donna and Sally used this goodwill to further recruit clinical assistants and patient care technicians as partners in patient care. In the usual care environment, the aids would wait until the contracted nurse practitioner would round 1-2 times weekly before bringing up larger issues or go directly to the Director of Nursing (DON) to relay any emergent patient issues. Without explicitly asking the aids to bring concerns straight to the embedded APRNs, Donna and Sally noticed that the care techs would grab them in the hallway and relay any concerning patterns they had seen in the residents. Sally contributed this acceptance to her proactive approach in rounding and helping care for residents using both her medical diagnostic skills as well as her basic nursing care skills. Charlotte also found the staff readily partnering and bringing concerns directly to her door because of her willingness to "*jump in anytime, anywhere*" which garnered her a level of legitimacy.

If these previous examples prove the concept that demonstrating basic skills establishes legitimacy, then the following anecdote will demonstrate this idea through illustrating the opposite. Carrie and Kelsey found a very different culture that was more closed off and not accepting of more new nurses stepping in in any capacity. Instead of being helpful they felt "*dismissed*" with Carrie stating in the facility "*the asylum is run by the inmates*". She wasn't actually referring to the residents in this case but was using a colorful idiom to refer to the staff who were very insular and had multi-generational longevity due to entrenched behaviors that

weren't responsive to management. Instead of being accepted, they instead were met with barely concealed derision and their help with patient care was not welcomed. This among other factors truly delayed their transition and ultimately resulted in Kelsey leaving the project before the completion of a full year.

Theme 2: Institutional Acceptance

Hospitable Environments

Facility Layout.

The very first visit I made was with Carrie and Kelsey in their facility revealed a facility unlike any of the others, with a unique structure and culture of its own. The patient population of this facility was focused on care of individuals needing long-term care but who also had contributing psychiatric comorbidities. The impression of the building as one pulled up was of a fortress with 15-foot-tall chain link fence encircling the facility, with locked gates and no landscaping. There was no welcome gate and I had to rely on waiting until someone brought their car through the gate to sneak inside the grounds. Upon entering the facility, I was greeted at the front nurse's station with an unsmiling nurse demanding to see my badge and asking me to sign into the guest book, an old-fashioned large ledger sheet. I spent some time observing, following, and meeting individuals all while enclosed in a building with low ceilings, few windows and low lighting. Residents meandered without purpose and interactions with staff were brief, superficial, and reinforced the power differential between staff and the residents. The whole encounter and the set-up of the facility left one with a feeling of unwelcome. In fact Carrie, would say in one of our later interviews "*we are doing work that no-one pays attention to*" and the residents, "*they consider it jail*".

In contrast, Victoria and Alison were placed in a very bright, airy, and welcoming campus. Upon entering you are immediately greeted by a personal receptionist and the first area you encounter is a well-appointed reception complete with coffee-house style snack bar. Google ratings of the two facilities reflect these differences as do the care ratings by CMS. In our first meeting Victoria and Alison repeated many times how "*beautiful*" and "*lovely*" their facility was, comparing it favorably to others in the project. Later however, Victoria and Alison ran into different issues which impaired their ability to transition, but the physical structure of their facility was not one of the reasons.

In between these two extremes lies Donna and Sally's facility, which is located in a smaller town further outside the metroplex than where the other facilities were located. While their facility was built around the same time as Carrie and Kelsey's facility, they could not be more different in appearance and welcome. The grounds were well-kempt, landscaped, and even though they were locked, the gardens did not feel like a jail. On the inside, the ceilings were low as was the style in the 60s and 70s, yet the facility felt clean, spacious, and well-lit. Staff readily mingled with the residents and there was always purposeful movement and genuine interactions of concern between staff and residents. Four-five months into the project, Donna described feeling "*at home*" and "*part of the family*".

Provider Space.

Continuing the theme of facility welcome, the APRNs were greeted with very different working spaces, which reflected a greater feeling of welcome and bore a direct relationship on their ability to transition into practice. Donna and Sally were given their own small, but private office complete with a door that would shut. At first Sally was flippant about the "*door that closes*" but then confessed that it was absolutely "*necessary*" in order to chart and do her work as

an advanced level provider uninterrupted. Space created the opportunity to transition into her role.

Charlotte was also assigned a dedicated workspace, but this was initially in the same small office as the DON and was "*waaaay too busy*" to accomplish her advanced practice duties. Instead, Charlotte was often involved in not just patient care problems but found herself involved in administration-level concerns such as staff disagreements and even breaking up staff fights. Within a few months, Charlotte was given a quieter corner of the rehabilitation room which was a "*great improvement!*" according to Charlotte because although it was not private, it was relatively removed from the center of administrative action. Observing Charlotte in this environment found her much more relaxed and at home in her space- this space allowed her to better realize and transition into her advanced practice role. Again, space created the opportunity for Charlotte to transition into her role.

Conversely, Carrie and Kelsey were the most disadvantaged of the APRNs in terms of their workspace as they were given none. Their facility had a large conference room that served about 5-6 different purposes including storage, dental office for monthly dental visit, recreation room and finally, APRN office. The furniture in this room was a hodge-podge of broken, mismatched, and dirty items, and shelves filled with miscellaneous storage items (most outdated). Carrie was flustered and very embarrassed during our first meeting and was on the verge of tears. Kelsey had gotten into a routine of three, 12 hour days, which often left Carrie on her own several days of the week as she continued to work eight hour shifts, five days a week. Carrie confessed to being embarrassed, scared, lonely, and disgusted by her workspace. She kept wiping our areas with sanitizing wipes and lamenting the fact that the conference room was "*so dirty*". "*I can't work in this environment*" she said but then capitulated and clarified she meant to

the office-space, not the facility in general. On that note she said, "*there's so much to do, it's kinda overwhelming*", and her attitude vacillated between hopelessness and hopefulness and she said she had "*found ways*" to "*make it happen*" and work within the space they were given. The CEASLTC administrator advised Carrie to advocate for an office space as this was a part of the initial agreement between the facility and the TXHHS/CEASLTC collaborative study. It took another one to two months, but Carrie and Kelsey finally were given a screen that allowed them to carve out their own space in a corner, "*less than ideal*" but still "*a vast improvement*" over their initial set-up. Lack of welcome was reinforced through lack of space and delayed Carrie and Kelsey's ability to transition- the institution was not welcoming.

Institutional Mission.

The values espoused by each organization had a direct impact on the APRNs ability to adjust, transition and feel welcomed in their facilities. Victoria and Alison's facility had the most "monied" feel of the facilities with its snack bar and bright, airy building. Their stated mission focuses on feeling modern, new and with a "culture of hospitality" and with a focus on clinical care vs residential care. Victoria and Alison had difficulty finding their purpose in the long-run because the systems and practitioners already in place for acute care did not welcome an embedded APRN and Victoria stated feeling "*redundant*". Mission created acute care focus that didn't value the embedded nature of an APRN to monitor long-term residents. Instead, the mission crated a structure that prioritized in-place acute care teams that did not welcome APRN "*meddling*" in patient care.

Natalie and Jenny were in a facility that advertised "family tradition" and ownership of one family in a mostly contiguous fashion, other than a two-to-three-year period where they were run by an outside management company. Natalie and Jenny came into this facility during a

transition period back to a family-run enterprise and could feel the effects which were overall hopeful with an eye towards improvement. Natalie expressed feeling welcomed and Jenny could feel the "*turbulence*" but felt it was "*getting better*". When asked about the familial aspect of the facility mission, Natalie felt this was mostly accurate and that the new administrators "*had best interests at heart*". Even over the next several months when the administrator turned over three times, the APRNs were included in all transitions and as Jenny said, "*it's a good thing*". There were obvious investments in the building and the facility (a wing conversion, gym rehabilitation, and new flooring throughout) which caused turbulence, but in a hopeful way.

Finally, Donna and Sally were placed in a facility that prided itself on local ownership, longevity of top administrators, but most importantly, the facility ascribed to a care philosophy called the Eden alternative (The Eden Alternative, 2011). Donna animatedly helped explain this philosophy to me in our meeting "*words have meaning*" and this approach allows for "*refocus on people*". LTC residents are not referred to as residents, but as Elders or by their name (The Eden alternative, 2011). Donna and Sally were welcomed quickly into this environment with Donna stating "*they really do care and call the residents Elders"* to "*show respect*". Transition was almost seamless as Donna and Sally were able to slip into the family system of the facility and readily find place. Of all the LTCs, this facility had the most resident-centric focus which was reflected in, and supported by, longevity of administration and staff. The word "*family*" was used by everyone, administrators, staff and APRNs, which was evidenced by the daily interactions between residents and staff. Comfort was prioritized and staff created a "*home*" environment.

Personnel Welcome

Support from Administrators

When the participating LTCs agreed to join in this research project, Administrators were interviewed and had to be "on board" in order for NPs to be placed in their facilities. Strangely, even given this pre-screening, not all administrators understood the role of the APRN or how best to support their transition to practice. In an interview with Brian, the administrator overseeing the facility where Donna and Kelsey were placed, he expressed a "*wild idea*" to hire an APRN but have them split their time evenly between functioning as a Director of Nursing and as a Nurse Practitioner. This revealed an ignorance on Brian's part about what the APRNs were charged with accomplishing and was reflected in Carrie and Kelsey's general lack of welcome and underutilization over the course of the project. Carrie was disheartened by the staff's overall lack of caring and participation in improving the facility, but she voiced "*admin says 'my hands are tied, I can't fine her, I don't have a replacement'- look around who wants to work here!*". Kelsey became so frustrated and failed to engage with the facility that she left the project early, and Carrie slowly progressed from an attitude of hope to one of hopelessness.

Victoria and Alison met similar confusion over their roles in the LTC, and the administrator seemed only interested in using the APRNs for quality monitoring purposes, not daily patient care as you would expect from an embedded practitioner. This so frustrated Victoria that she left the project only 5 months into her tenure, followed within weeks by Alison, because she "*wasn't allowed to see patients*" due to provider competition with rehabilitation provider teams and was not given support for her role by administration. In fact, when I met with Victoria days before she submitted her resignation, she did not let on she was contemplating resigning, but her language and tone had shifted to one of nostalgia around her previous role as a hospital-

based nurse providing patient care. We shared a registered nurse background in a critical care environment, and on this visit, Victoria was mostly interested in relaying her fond memories of "*being a real nurse*" and the satisfaction that comes with "*laying hands on*" your residents. She was waxing poetic about the beauty and satisfaction that came from her competence as an ICU nurse. You could feel that she missed being an expert and was tired of being a novice. Her transition was stunted, and this led to her reminiscence of better times. After the departure of Victoria and Alison, Sally transferred to this facility on her own with 4 months left in the project. She encountered similar confusion over her role, but her years of experience made her better able to negotiate her responsibilities. Charlotte summed up a lot of the APRNs opinions and struggles; "*facilities didn't understand what we were there to do*?".

The best example of administrative support easing APRN transition came from Donna and Sally's facility. In an interview with the administration, Priscilla, she expressed great interest in working with the facilities board of directors to get an extension to keep Donna on board for an additional year as an embedded practitioner. At the end of the first year, the facilities had the option to continue employing the APRNs and covering 50% of their pay. Ultimately Priscilla was the only administrator who pushed for this option even though she was eventually turned down by the board of her LTC. Priscilla also provided material support to the APRNs to help them settle a dispute with the Medical Director and his contracted APRN over competition for billable care. This incident ended up causing Sally to ask to be moved to another facility halfway through the project, even though Priscilla offered to mediate and keep Sally on board. After this skirmish between the providers and the embedded APRNs, Priscilla worked to ensure Donna was still supported and had all the access and equipment she needed to perform her duties. Per the

administrator, Donna was a "*whole-hearted part of our family*" by the end of the project, and Priscilla was a converted champion for this care model of embedded APRNs.

Theme 3: Personal Role Fulfillment

Intrinsic Factors

"I'm confident, I'm smart, but….."

The nurses displayed varying levels of intrinsic drive to remain engaged and seek out their own transition experiences. Most expressed initial confidence in their abilities to perform their role as an APRN but then encountered moments of, or even ultimate self-doubt once they were in the field. Charlotte stated "*I'm confident, I'm smart, but….* " she let her voice trail off with the emphasis on the "*but"* indicating continuing insecurity. "*The first month I was on edge, I didn't really know where to start*". Charlotte also had the disadvantage of both being the only APRN with no previous RN-level experience or APRN level experience and she was placed alone at a facility furthest from the CEASLTC offices. But overall, Charlotte maintained confidence in her skills and at the end confessed "*I learned so much*" and "*I try to make the best of whatever*". She was even a finalist for a similar APRN LTC position at a facility out of state for when the project ended, but unfortunately that job fell-through due to the COVID-19 pandemic and facility reorganization.

Carrie started out with more confidence based on her years of APRN experience and on our visits would initially demonstrate comfort in her role even with her expressed disappointment with lack of staff engagement. She developed modules early on for staff education but ultimately the place "*wore her down*", "*everything I have done here has done nothing*" and "*at this point I am done with this place*". Even with her previous APRN experience, Carrie was not able to successfully transition to an LTC position and instead voiced "*I am*

looking into doing something else where I can make my own decisions". The decision to stay on with the project through ups and down was driven in large part due to internal motivation to "*make a difference*" in the resident's lives. Carrie said, "*if I wasn't dedicated to stay to the end, otherwise I woulda quit*". Carrie expressed the most hopeless emotions of the group and opted for a break in employment at the end of the project. "*In my own self-discovery, I wasn't taking care of myself- my only real human contact was with people (who) don't care*". "*After a year of frustration, I'm just done- I was so hopeless with all of this stuff*".

Meetings with Jenny and Natalie showed a group dynamic that helped Natalie find confidence in her abilities through initial mentorship and partnership with Jenny. In our first meetings, Jenny would be the one to mostly explain their routines, but fairly quickly I observed Natalie stepping out and narrating and demonstrating more of her daily activities. By the end of the project, when the facilities were in the decision mode of whether to take the APRNs under contract for one additional year, Natalie expressed confidence in her facility signing on- just not signing on *her*. She was so convinced that the facilities would go with Jenny, the APRN with more experience, she actually applied and took another position before the end of the project. She had gained confidence as an APRN but had not transitioned into the LTC setting well. Through conversations with the Lindsay, the DON, the facility was more likely to have signed on with Natalie as the APRN and ultimately decided not to keep an APRN embedded in the center once Natalie left the project. Interestingly, the facility had transitioned to appreciate an APRN, but wanted certain qualities in hiring that Natalie met but not Jenny. While Nancy had transitioned well into a confident advanced practitioner, she has not found a "home" in LTC. This lack of communication between the facility and the APRNs was concerning though and indicated a disconnect that could jeopardize longevity for any APRN hired into this role at this

facility if their personal practice needs are not identified and met by administration; even if they had intrinsic factors that assisted TTP.

Meeting self-expectations

Transition to practice was greatly affected by the participants ability to meet their own expectations through their assigned work. Sally expressed frustration that she could not accomplish more in relation to the project stating at her second assigned facility stating, "*I think I could have helped them out quite a bit more*", "*If they had just considered utilizing me more*". Before decamping from her original location, Sally derived great satisfaction in helping the facility gather information for a prestigious quality rating application. COVID-19 isolation also led to feelings of discouragement as Sally stated, "*I believe at XX, I would have been able to do both (quality improvement and patient care)- they were like 'oh help me whenever you can'*.

Charlotte also experienced limitations due to the COVID-19 pandemic which actually shut down her facility approximately 2 1/2 months before the end of the project. "*I wish things had been different*" she said and "*I feel like year two would have more experience and (I) could get more out of it*". "*XX was a good experience, but it was a little too much of everything*". "*I didn't have enough time to make change*".

The most glaring example of the APRNs unable to meet their own expectations for care, came from Victoria and Alison. The facilities refusal to allow them to see the majority of the residents in the facility created an almost boredom and lack of direction to their days. Victoria summed it up best when she said she felt "*useless*" and "I *don't get why we're here*". The administration and medical director were open to the embedded APRNs playing a large quality monitoring role, but this was not what these APRNs had in mind. Victoria's remembrances and

almost romanticization of her critical care RN days made clear what her expectations were that were not being fulfilled, hands-on patient care.

Donna was the nurse most able to meet her personal expectations and was very excited to potentially stay on for the next year. While the board of her assigned LTC ultimately decided not to take on an embedded APRN for the next year, they were willing to keep her on for eight additional weeks to help coordinate and organize the facilities response to the COVID-19 pandemic. "W*e still made a difference*", she said.

Theme 4: Provider Relationships

Provider Competition

Negotiating Care with contract APRNs- "Who does what?"

The usual model for LTC medical care relies on APRNS that are contracted with medical providers (sometimes the facility medical director) to round several times a week on residents to identify any issues that require attention and orders. The APRNs embedded in the LTC facilities were envisioned to meet two objectives: 1) provide patient care as needed between contracted APRN or Medical provider visits on a daily basis and 2) identify quality improvement initiatives through data collection and analysis and then design quality improvement programs including staff teaching and practice change. The APRNs ability to meet these objectives directly impacted their transition and intention to stay in LTC. Victoria and Alison met immediate resistance to half of this model and were actually "*forbidden*" from rounding on approximately half the residents admitted into their facility. There was little interaction with the contracted APRNs and the medical providers for those residents because there was no need for coordination. The two teams were siloed in their care.

Initially, Sally and Donna enjoyed good coordination with the APRN partnered with the Medical Director. However, this seemed to sour suddenly after several months. The contracted APRN and MD came to the administrator and claimed there was conflict of interest with as Sally put it, "*going out of her bounds*" in writing orders for residents between the APRN visits and "*not communicating enough*". Though Donna believed "*Dr. X was worried about me taking money away from them*" it was the contracted APRNs perceived reduced patient visits that triggered this response. For some reason, which the APRNs were not able to articulate, the blame for this '*overstepping*" fell onto Sally and not necessarily onto Donna. Overall, Sally had a much more dominant and vocal personality and I believe her presence was perceived as threatening, whereas Donna's calm, quiet demeanor was not. Sally's transition was interrupted, and she asked to transfer facilities, but Donna's was able to continue.

The greatest levels of coordination between the contracted APRNs and the embedded study APRNs occurred in Natalie and Jenny's facility. Both Jenny and Natalie were on a comfortable first name basis with the contracted APRNs and both teams participated in weekly quality team meetings. When I observed their interactions, they were casual, collegial, and the providers shared equal expertise. Both teams were included in the quality presentations and the administrator sought feedback on residents from both teams. Both Natalie and Jenny expressed satisfaction and were progressing through transition well, right up until COVID- 19 caused disruptions in their facilities and access to patient care. As COVID-19 came on the scene, it required both APRNs Jenny and Natalie to quarantine for 14 days each due to potential exposure. This absence from the facility marked a real change in the perception and use of the study APRNs. Whereas before they were "*part of the team*" with discussions reported by Jenny on "*how to keep at least one APRN onboard* (after the 1year study end)" but now they were

sidelined, and their expertise was not sought out or included in either medical or quality issues. Ultimately the DON voiced concerns that the APRNs were too distant and self-concerned when the pandemic hit and that she would have "*appreciate(d) the help*" with the additional regulatory issues that arose from COVID-19 regulations.

Medical Director Support

Support from the medical team was one of the greatest challenges for the embedded APRNs to negotiate. Typically, Medical Directors (MD) are physicians contracted with multiple nursing homes and LTC centers to meet Medicaid assessment and medical management compliance and are not embedded within the facility. They do visit regularly, but mostly rely upon contracted APRNs to complete rounds and respond to patient care emergencies. Callie, a contracted APRN in one of the project facilities stated her relationship with the medical director was "*good*" and "*we've been working together for years*". Subject APRN responses to their relationship with the assigned MD ranged from indifference to perceived competition with only Charlotte, Jenny and Natalie expressed consistent MD support. According to the CEASLTC director, at the onset MDs were most excited by the prospect of the APRNs performing quality improvement data collection and implementation of quality improvement projects as opposed to the idea of the APRN as fellow primary care provider. Though the study was designed for APRNs to both embed within the facilities to assess residents, as well as perform quality improvement functions, the medical teams had difficulty embracing the embedded APRNs as partners in ordering and directing individual patient care.

Across the course of our interviews and observations, I observed and the APRNs reported coordinating with the contracted APRNs or with their partnered study APRN more than with the MDs. The APRN who had the most interaction with her MD was also the APRN with the least

experience (no previous APRN or RN-level independent experience) and no paired APRN at her facility. Charlotte did voice "*I felt like putting out fires, it would have been easier if there were two*" perhaps indicating she did need further guidance as she transitioned into practice in both a new provider level and environment. When asked if their relationship with the MD was essential, the general response was lukewarm; from "*sometimes*" to "*it's an extortion racket*" (referring to the necessity of contracting with a medical provider as required in this state who then will receive 15% of your income for services rendered, "*whether used or not*"). Toward the end of the study when asked if any of the APRNs felt the MDs of their facility would take them on as a partner once the study was over, only Charlotte expressed "*potentially*", and Jenny said she believed she would be hired on to the unit if they opened their renovated wing soon. This exposes a lack of acceptance and support by the MDs of the APRNs as partners in care which threatens their transition to practice.

As covered earlier, Victoria and Alison encountered the most resistance from MDs and were barred from rounding on approximately half the residents in their facility demonstrating a lack of trust and buy-in from the medical teams. At their facility, Donna and especially Sally, encountered direct conflict with the MD which required mediation by the facility administrator. Per Donna "*Dr. X was worried about me taking money away from them"* and this "*could be one of the biggest issues to this program working*". Priscilla the administrator revealed the medical director in this instance "*had ideas of how to generate billable income (*together*)*", but he never initiated talks on his ideas with the APRNs or the study group and relied upon the administrator to negotiate between the APRNs and his team. Priscilla also referred to the difficulty of establishing relationships that jeopardized collaboration:

> "*the biggest issues that we had, had to do with how they integrate with the existing nurse practitioner and the medical director who has to oversee them. They don't have a relationship prior to coming here or, you know, they don't have any built rapport. It's hard to give comfort level for moving forward*".

Sally described being "*sidelined*" by the medical team and requested a transfer to another facility. Priscilla provided insight into why: "*they're looking at visits and billing, and I'm looking at the whole picture and all the things to do that's outside of just a visit that's billable that benefits the nursing home*" and "*really it sounded like they wanted them (*the APRNs*) to talk to them (*the MD and contracted APRN*) more before they made decisions*".

Sally then moved to the facility that was vacated by Victoria and Alison, and she expressed at her second facility the administrator was most interested in her help on QAPI (quality assurance plan), but that the MD was not as involved in QAPI. She wasn't being used to her full potential and encountered the same patient assessment restrictions that bothered Victoria and Alison. Carrie also encountered issues, but hers were with orders being tucked away and not followed. Her impression was that this was an extension of ongoing staff-level incivility, but she was also discouraged at not receiving MD support: "*there is a process (*to resolve medical issues*) but it is not being followed*" further adding to her increasing hopelessness. Charlotte did express a good relationship with her MD and reported using his expertise the most easing her transition to APRN practice in the LTC environment.

Theme 5: Individual Care vs. Organizational Care

Role Confusion

Preference for Primary Patient Care

When APRNs were hired into this research project, they were made aware of the twofold purpose of this study: 1) to embed within the LTC facilities for daily patient care needs from a provider and prescriber perspective, but also 2) to monitor quality improvement parameters and to devise quality improvement projects, staff education, and identify additional monitoring needs for compliance. Conversations with most of the APRNs about their transitions initially were solely focused on patient care and the establishment of daily activities such as rounding on residents, establishing rapport with staff and residents, and inserting themselves as part of the team care routine. Though several expressed dismay at the state of their facility care, planning quality improvement initiatives was not part of their initial conversations or actions. Initial actions around establishing legitimacy as a provider were focused on patient care activities as if to prove to the aids and nurses, they were still "nurses" in spite of their advanced pedigrees.

The difference between those who focused on primary care and those who were able to jump right into quality improvement mindset depended on the stability and focus on the LTC facility itself. For example, Victoria kept her narrative on "*gaining access*" to residents due to medical provider resistance and she expressed a real longing to provide one-on-one patient care as she was used to in her previous critical care role. She felt even though she had an advanced practice degree, this role was a "*demotion*" of her capabilities and her expertise was not being utilized. Charlotte was so "*overwhelmed and I don't know where to start*" as she stepped into a facility that suffered from staff infighting and relied upon her RN-level skills at first to attempt to gain legitimacy. Carrie and Kelsey were met with a borderline hostile environment, lack of

space, welcome, and understanding which truly impeded their ability to dive into quality improvement. Though Carrie did share in our first meeting how she had identified missing compliance with patient safety (restraints, falls) and she had developed an infographic for staff training about these compliance issues. However, she expressed true discomfort and lack of confidence in her deliverable asking over and over "*is this what you wanted*", "*will this work*" and it took her several months to finally host a training for staff. The dysfunction she encountered lead to lack confidence in her abilities and she instead focused on patient care routines at first. As Carrie would later confess "*everything I did hasn't been implemented*".

Discomfort with Quality Improvement

The second directive for APRNs on this project was participation in gathering quality improvement data and designing projects for improvement. Training was given during the classroom phase of onboarding by TXHHS about the Quality Assurance Performance Improvement (QAPI) program which expects "nursing facilities to apply quality principles to the person-centered approach of resident care" in order to follow state and federal regulations. At the same time, the APRNs were given a directive as part of the HHS study to collect data as part of the HHS study to determine if embedded APRNs improved patient outcomes.

Participation in QAPI was sporadic in most facilities except for Natalie and Jenny and Sally and Donna. Though Victoria and Alison worked at a facility with an active QAPI program, they were initially not involved to a great extent in QAPI initiatives. Once these two APRNs had left the program and Sally transferred to the same facility, she did have a great deal of involvement in QAPI. The administrator at this facility, Steve, was very difficult to pin down for an interview, but at the very end of the project I was finally able to get some time with him. According to Steve, QAPI was a great "*opportunity*" and he looked forward to having Sally

participate and guide quality improvement projects. However, Sally found conflicting responses to her presence, *"I believe we could have been more involved with QAPI*", and *"(with the) QAPI aspect we weren't allowed to do (a lot more)*" which was probably influenced by the COVID-19 pandemic that shook the LTC world towards the end of the study. Sally did confide that at her 2nd facility "*I believe at X, I would have been able to do both (referring to patient care and QAPI aspect*)" and *"they were like 'oh help me wherever you can'*. Being forced to work outside of the facility, along with the all-consuming focus on LTCs on procuring PPE, and the daily changing recommendations for safe patient care during the pandemic caused many routine functions to fall by the wayside for the last 3 months of the project, which coincided with Sally's tenure at this 2nd facility. Sally was very involved in collecting data for the quality component of the study in both facilities, which reflects her comfort with regulatory environments from her previous years of LTC experience. Donna also expressed comfort with data collection, again a reflection of her experience running a clinic in her APRN capacity in another state and experience with quality and compliance issues. Even with her grasp of the importance and ability to quickly gather data, Sally expressed a true desire to want to help the residents (or Elders as they are called in her assigned facility) "*I wish they would use me more*" but showed a preference towards hands-on daily care instead of data-driven organizational care: "*I want to take care of patients, not sit in front of a computer all day*".

Natalie and Jenny were very active in QAPI meetings and facility initiatives from the beginning bringing more comfort to their quality role. However, even this team expressed confusion over the differentiation between QAPI and the quality parameters being collected for the study. The expressed a profound discomfort in finding initiatives "*on their own*" that were not informed by the overall QAPI team. As Natalie asked during the 2nd month in the facility

"*what are we supposed to be doing again*?" It was apparent they were uncomfortable with stepping out to collect data on their own (QAPI data is managed by the QM nurse) and recommending quality initiatives independent of the overall QAPI team. Even though Jenny had previous APRN experience, it was as an APRN in a team which contracted with facilities for care and did not own the quality improvement process, and Natalie was brand new to APRN level care.

As already stated, Carrie was able to produce some quality improvement initiatives, but found resistance in her facility to its implementation. In regards to the quality data collection to prove her value, Carrie confided "*I'm not sure what I am supposed to be doing*". Her facility was a "*real mess*" and ultimately the QM (quality management) nurse filed a complaint with the state to review their procedures after COVID-19 caused disruption and confusion. "*Every time I turn around there's something screwed up there*". Carrie required multiple reminders to turn in her quarterly data collection for the study and expressed "*it's so overwhelming where do you start?".*

Charlotte divulged that "*I don't know enough about that*" in regards to data collection, and her data was indeed "unclean" and had inconsistent start dates throughout requiring cleaning on the part of the research team. Towards the end of the study, she revealed "*the way they asked for the data was very vague*" which exposes her lack of knowledge about what she didn't know in regards to data collection and she didn't ask for clarification earlier in the study. Even with her overall lack of nursing experience, Charlotte tried to "*make the most of it*" and dove right into the obvious day to day care of residents but struggled with the larger concept of caring for the organization through improvement initiatives. In terms of transition, the primary care aspect of APRN care was close enough to what was familiar, but the organizational level concepts of quality improvement were more removed and more difficult to grasp.

Discomfort with the Billing and Regulatory Environment

In order to create a cost case for embedded APRN care in the LTC setting, the APRNs were asked to track their billable activities and report these back to the TXHHS/CEASLTC team. Unfortunately, most APRNs were new to practice and had little to no idea how to "bill" activities. Training was provided in billing using Current Procedural Terminology (CPT) codes as well as International Classification of Diseases, 10th revision (ICD-9) codes for ensuring accuracy in billing. This particular aspect of advanced practice nursing was frightening for the new nurses and overwhelming. When working to gather this data from the APRNS, it became apparent that they were initially missing opportunities to bill for their services through care meetings and some billable procedures and different APRNs billed visits in different ways. This boiled down to lack of training and knowing what was allowable for billing under Texas scope of practice and how to use charting to justify the assigned bill. The threat of committing billing fraud was ever-present on the APRNs minds. Charlotte who used the higher-billing codes more readily stated "*I was told to bill what I did, so I did*", but Carrie who used lower-billing codes more frequently approached it from the opposite standpoint, almost as she feared to "*get caught*" doing something wrong "*they get you for over **or** underbilling".*

I felt real empathy towards these APRNs who were learning to code for the first time as I struggled to make heads or tails of the codes and when to use one over the other. I am a nurse with an advanced degree, but not an advanced practice nursing degree, so I have no experience or training in billing services. As I wrestled with learning this seemingly herculean task, I turned to my teaching colleagues in an NP school for advice. I was told "*oh girl, we try… that's the golden goose… we don't have a lot of time to cover that*". "*We give them handouts and hope for the best*" and she helpfully emailed me some handouts on how to use different codes. I even

failed to find a comprehensive online resource, finding the CMS site more confusing than helpful. In desperation, I turned to a good friend, Sean who is newly graduated from NP school himself. According to Sean, he doesn't have to worry about billing codes because he is part of a team that contracts out his services to various clinics and this team utilizes a billing service. His focus was on learning charting codes to ensure he charted his diagnoses accurately so that the billing service could use this information to accurately bill. I suddenly came to the realization that the APRNs were uncomfortable because most APRN graduates only received a cursory education in how to bill, because a large number would never have to bill independently. Charlotte confirmed this stating "*we talked about it, but I've never done it*". With this new knowledge, I turned to Donna who had the most experience with the regulatory and billing environment from running her own state clinic in another region of the US. She confirmed that it was an overwhelming experience, and it turns out she had become the resource of choice amongst the study APRNs to help with this process. Likewise, she became my confidant and guide as I learned how to bill and what the different codes indicated. The thought of learning billing "*on the fly*" as my teaching colleague put it, while solidifying my practice made me appreciate what a barrier to transition this task posed for our APRNs with no experience in this skill.

Summary

This chapter reviewed themes that developed from observations and interviews with a purposive, purposive sample of APRNs transitioning into practice in a new environment, the LTC. Reflexive analysis of findings revealed themes of; 1) Legitimacy as Provider, 2) Institutional Acceptance, 3) Personal Role Fulfillment, 4) Provider Relationships and 5) Individual vs. Organizational Caretaker. The next chapter will focus on presentation of thematic

data centering on the research questions that guided the ethnographic observations and interviews, to then set the stage for interpretation of the transition experience and how the APRNs and the organization influence each other interdependently through this process.

Chapter 5: Discussion

This ethnographic study explored how APRNs experience transition to practice into a new practice environment, the LTC setting, in the Central Texas region of the United States. Transition to practice is not necessarily linear in nature but it is a complex process characterized by insecurity whether the individual is new to the profession or new to the area of practice (Yeager, 2010; Chicca & Bindon, 2019). Brown and Olshansky (1998) have labeled this transition process for the APRN as the "Limbo to Legitimacy" theoretical model, envisioning the nurse as a craftsman laying a foundation to build upon. Transition is presented as a linear model from 1) laying the foundation, 2) launching, 3) meeting the challenge, and 4) broadening the perspective. Yet as the authors are quick to point out, this progression is neither linear nor are the categories of progression mutually exclusive. Individuals in transition can vacillate between the levels, experience multiple levels simultaneously, and can even skip ahead depending on the obstacles or facilitators encountered along the way indicating this process is actually complex in nature (Brown and Olshansky, 1998). Our team of APRN subjects demonstrated that they not only experienced transition to practice on different trajectories, but also at different timeframes in a complex nature, and sometimes not at all.

We are concerned with effective transition into practice for nurses in LTC environments because there is a shortage of providers (both APRN and physician) experienced with gerontology and there is continued financial disincentive for physicians to specialize in this practice (Golden et al., 2015). Evidence also demonstrates that APRNs improve patient outcomes in LTCs where they are embedded. The cost of care delivered by APRNs promises to provide cost-savings for LTC facilities while still providing equal or better care in several parameters include rehospitalizations, hearing/vision screening, and end-of-life care (Unroe et

al., 2011; Vogelsmeier et al., 2015; Devereaux Melillo et al.,2015; Petriceks et al., 2018).). The APRNs participating in this ethnographic study demonstrated how transition is not guaranteed, regardless of previous experience and dedication to the setting, but instead is reliant upon multiple factors including institutional welcome, personal role fulfillment, provider welcome, role confusion and the struggle for legitimacy.

There has been speculation and conflicting research into factors that affect APRN transition to practice, with multiple studies showing that lack of a formal transition negatively affects transition, while presence of a transition is positively correlated with retention (Cusson & Strange, 2008; Goodwin et al., 2009; Flinter, 2010; Sullivan-Benz et al., 2010; Stock, 2015; Han et al., 2018). While there are active TTP programs for RNs such as Versant© and Elsevier online, there are fewer transition programs available for APRNs. Typically, APRNs attend a graduate education for 2-3 years to prepare for entry level practice, but there is no formal requirement for a residency period. This contrasts with their physician peers who attend a 4-year medical-school education plus 3 years of formal residency. The 2011 IOM report, *Future of Nursing* recommended further action be taken to support nursing transition to practice programs at all levels, including APRNs. Action was recommended that state boards of nursing, Heath care organizations, CMS and Secretary of Health and Human Services all work together to set standards, accreditation and provide funding for formal transition to practice programs for nursing (The future of nursing, 2011). According to a survey of 689 NPs, 58% were “extremely interested” in participating in a postgraduate NP residency program if one was offered compared to only 2% who were “not interested” indicating a widespread interest in these programs. Currently, APRN transition falls mainly on organizations to provide formal residency programs such as the Mayo Clinic, Emory, Johns Hopkins, and state agencies such as TXHHS (Boyar,

2012). While our study cohort of APRNs did undergo classroom orientation, they did not have formal residency program, consisting of graduated practice and mentorship, available for their transition to practice period. This study has helped to identify what worked for transition, what did not work for transition, and what are the broader implications for organization and healthcare level policies.

Themes with Research Questions and Literature Review

In this section, I work to apply the thematic findings of this ethnographic study to the research questions which were informed by literature search. Simultaneously, I address how both the APRN and the environment interdependently transformed each other (or not) through their transition experiences.

Aim 1: What are the experiences of APRNs as they transition into a new practice environment in the LTC setting?

Research Question 1.1- How does the practice environment influence the APRN transition?

Research Questions 1.2- How does the APRN presence transform the practice environment?

As the sample of APRNs experienced transition, there were multiple influences on the environment that both facilitated and impeded transition into this new practice environment. Using CS as the guiding framework, the APRN functioned both as a CAS within herself, but also the environment acted as a CAS centered around accomplishing patient care of which the APRN was a component. By observing and being attuned to how culture was co-created in the environment between the APRN and the care situation, I crafted themes related to the influence

of the environment on APRN transition and how the APRN helped transform the practice environment.

Theme 1: Legitimacy as Provider

Legitimacy as provider was influenced by openness to the APRN role by the organization but also by individuals in the LTC setting such as the medical provider, administrators, and staff. Dillon et al. (2016) reported a positive correlation ($r=0.49$, $P<0.1$) between organizational support and comfort/confidence in Acute Care NPs transitioning to practice, which reflects the experience seen in our sample. Victoria and Alison were met with cultural resistance from an organization with a mission more focused on acute care and a medical provider team that did not welcome or allow their performance at an advanced practice level. These two new APRNs reverted to basic nursing skills to attempt to win back legitimacy as providers but were ultimately unsuccessful. Schlossberg wrote in regard to transition of adults and refers to an interesting concept called “non-events”- an expected event transition that does not happen (Wall et al., 2018). Victoria and Alison could be regarded as experiencing a non-event, failing to successfully transition into an APRN role in an LTC. Likewise, Victoria and Alison were unable to leave an impression on the facility and their presence passed almost unnoticed. Once they both departed the study, the facility continued to focus more or less as it had before they arrived.

Charlotte however was able to negotiate use of her basic nursing skills to gain confidence and ultimately find successful transition into the fabric of her organizational culture. By building up her authority through unashamed and unabashed involvement in all levels of patient care, she established herself as a patient-centered caregiver and an asset to the organization. Through these actions, Charlotte built space for herself within the organization which ultimately allowed her to accomplish her transition and realize her role as an advanced practitioner. The opportunity to

practice and improve skills allowed Charlotte to feel empowered facilitating her role transition (Almost & Laschinger, 2002). Her presence was then able to affect the organization and change the way care was provided. Charlotte met the needs of her residents and provided guidance to aids and the DON alike. Her presence was so valued and respected by the end, Charlotte was included as an integral part of the organizational transition to closure and relocation of residents due to the COVID-19 pandemic. Her expertise was valued, appreciated by the organization, and in turn Charlotte found confidence and successfully transitioned into seeking out similar APRN roles in her next position.

The phenomenon that Victoria, Alison and Charlotte are all experiencing is embedded within the From Limbo to Legitimacy theoretical model of transition. Within this theory is the concept of *liminality*, a term indicating one is "straddling two identities while not feeling a part of either" (Sanger, 1991; Brown and Olshansky, 1997, p. 6). The APRNs in this study demonstrated this liminality as they straddled their old world as either an RN or an APRN with experience in another field, while attempting to lay the foundation for practice in a new environment. They struggled with two levels of threat to their legitimacy, both from the daily personnel such as aids and LVNs/RNs but also from other medical and administrative personnel. One level wanted to know that the APRNs were helpful and not just another level of burden standing in the way of accomplishing care, and the other level wanted to know that the APRNs had expertise and value as medical and administrative providers. Barton (2007) identifies that as RNs transition to APRNs they must renegotiate their social and professional relationships. Successful negotiation of this liminality can help the APRN grow professionally, assume new roles such as education, leadership, research and quality assurance- establishing a new culture for both the APRN and the organization (Cussom & Viggiano, 2002; Barton, 2006; Pop, 2017).

Interestingly, liminality can be a source of advancement through transition as seen in Charlotte's use of basic nursing skills to ingratiate herself with the staff and establish legitimacy which ultimately did help her establish her credentials as a nurse with the staff and progressed her transition to meet the challenge and broaden the perspective (Brown & Olshansky, 1997). In contrast, we saw Victoria's inability to transition as she experienced liminality and was not able to transcend beyond meeting the challenge and left the project early. Her reliance upon stories and behaviors that emphasized the familiar and valued role she had as a critical care RN, and she was attempting to use this knowledgebase to build upon as she progressed to assessing, diagnosing, and treating residents in her new APRN role; however, lack of organizational acceptance and access to residents kept her in limbo and perpetually stuck in the launching phase of her failed transition (Brown & Olshansky, 1997).

Theme 2: Institutional Acceptance

The importance of institutional acceptance was exemplified by Carrie and Kelsey as they were met by an environment that was unwelcoming both physically and culturally. The fortress-like building, and the insular, closed ethos created by the inter-generational staff at their facility did not welcome change, especially when represented by outsiders embodied by the APRNs. Resistance was met at all levels, stagnant inertia was encouraged and cultivated keeping the facility organization-centered instead of patient-centered. The administrator was equally off-putting and did not enable an atmosphere where Carrie and Kelsey could function in their advanced practice role. They were unable to affect change and left no impact on the ongoing culture of the organization. Towards the end Carrie was very aware of this and in her interviews, she would often despair at the futility of her attempted interventions, and how her orders and actions were ignored or not even attended by the staff. Administration and even medical

providers were not supportive of the change the APRNs attempted to bring as exemplified by their inability and or refusal to enact culture change or enforce the expectation of staff to follow provider-written orders from the APRNs. Culture was not co-created and the APRNs were unable to even get beyond the launching stage of APRN practice.

A clear understanding of what the APRN role should be a central part of integrating an APRN into an organization with clearly defined goals and purpose. If the NP takes their role for granted and does not articulate their professional philosophy, it will be defined by others in the system (Judge-Ellis & Willis, 2017). This is particularly worrisome for new APRNs who are insecure, may not have even defined their own practice yet and often suffer from imposter syndrome (as seen in the first stage of Brown & Olshansky's Limbo to Legitimacy model). Sullivan et al. (2010) also reported in a descriptive narrative analysis that it is vital for organizations to be familiar with and understand the APRN role in order for these individuals to integrate into the organization. In the case of the administrator Bill, he had already decided that an APRN could function both as a primary medical provider but also in the role of DON, which violated Carrie and Kelsey's idea of their role and job description. This failure to agree on purpose remained unresolved and led to Kelsey's decision to leave the project early and to Carrie's confidence down spiral.

Conversely, Sally and Donna found a welcoming culture that included them in the organizational "family" and a welcoming facility that readily found space, time and understood their practice. The facility adoption of Eden principles allowed for a patient-centered experience and home-like atmosphere which enabled and valued the embedded nature of monitoring their beloved "elders" allowing Sally and Donna to realize their practice as APRNs. Their expertise was felt in an interdependent way with the facility, and their approaches were found to be

complementary to systems already in place. Both ladies were allowed to mingle and write orders as needed when problems were detected early between attending physician and or NP visits further enforcing the patient-centered culture of the facility. Sally was even asked to participate in completing a large and prestigious accreditation award application by the administrator. Donna and Sally were able to Meet the Challenge and Broaden the Perspective beyond just person level problems, to focus on the organization as a whole (Brown & Olshansky, 1997).

Natalie and Jenny also met a welcome environment where they were invited to participate in patient rounds as well as administration level quality meetings and rounds facilitating transition through all four stages of the Limbo to Legitimacy theoretical model. Vogelsmeier et al. (2015) developed themes from focus groups of APRNs that participated in a similar quality improvement program to this study and found a theme of "learning about the environment while changing the environment" (p. 95). Natalie especially had to learn and quickly approach the LTC as a complex environment which tested her as she was also new to the advanced practice role and insecure in her identity. As she began to transition and launch her practice, Natalie's language changed to one of insecurity to one of confidence and feeling of being valued. A positive relationship with the DON and administrator in her facility also allowed Natalie to be fairly proficient in not only the embedded primary care medical role, but also in her quality assurance and data collection organizational-care role. As Natalie was transformed to Meet the Challenge and Broaden her Perspective, she was able to potentially change the facility in the process by focusing on the initiatives of the quality improvement study. Unfortunately, COVID-19 did truncate this experience at the very end of the study, but Natalie did successfully transition to her APRN role, if not in the LTC, at least in a primary care role in her next accepted APRN position.

Theme 3: Personal Role Fulfillment

Realistic professional and practice expectations have a positive influence on transition to practice (Kelly & Matthews, 2001; Sullivan-Bentz et al., 2010). Transition is personified by role adjustment and NP tend to have very high self-expectations for a successful and smooth transition to practice during their first year (Sullivan-Bentz et al., 2010). Imposter syndrome is quite common with nurses with the impression that "others expect (you) to immediately have expert knowledge" (Sherman, 2013, para 4). A survey of new NP graduates (n=698), 37.4% felt "very strong" and 42.9% felt "strong" in relation to the question "Did you ever feel like you were practicing outside of your competence level?" (Hart & Bowen, 2016, p 548). Chick and Meleis (1986) define perception as an important element of expectation and transition, as individuals attribute meaning to transition events which varies from person to person and can make transition less predictable.

In the APRN study group, perception and expectations determined the individual nurses' ideas of self-fulfillment and lead to varied transition experiences in a somewhat unpredictable and complex way. However, the feeling of self-fulfillment was vital to the nurse's sense of success through their transition and predicted their willingness to remain in the LTC practice environment. Victoria felt stymied and "*redundant*" in her practice environment and unable to meet her desired goal of caring for residents. As evidenced by her reminiscing and nostalgic talk in regard to her previous proficiency as a bedside nurse with hands on expertise and relationships with her patients. The facility where Victoria was assigned did not see her in the same way and had different expectations for her role. Lack of congruency led to lack of self-fulfillment for Victoria and the failure to transition to APRN practice in the LTC setting successfully. Kelsey also was unable to fulfill her role either as a medical primary patient caregiver and as a caregiver

of the organization through use of data to identify gaps in care. The failure of the facility to welcome or find a role for her led to a violation of Kelsey's personal beliefs about her role and her expectations for her practice lead directly to Kelsey's early exit from the study.

Yet, this reliance on expectations for self-fulfillment opens the door for the influence of intrinsic factors to mitigate some of the other external factors on transition to practice and intention to stay. Horner (2017) found that the APRNs sense of self was positively correlated with job satisfaction and was closely associated with subscales of intrinsic factors, achievement, responsibility, advancement, potential for growth and recognition. In the rural health setting, which is not unlike the LTC setting, Owen (2018) focused on APRN transition into this underserved environment is often reliant upon APRNs utilizing intrinsic factors to find pride in helping underserved communities. Even though the rural environment is challenging from a transition standpoint and APRNs are often overwhelmed and lacking in mentorship access, desire to serve in this setting can minimize some of these challenges and make transition more likely to succeed (Owen, 2018). In the APRN study, Charlotte showed strong intrinsic factors such as intention and responsibility and her resilience to complete what she set out to do- transition to practice in an LTC setting. Her language created a narrative of resilience; "*sticking it out*", "*I try to make the best of whatever*", and "*I can't say no*". Charlotte was driven by a strong internal compass to complete what she set out to do and explained to me this was due to her skin color, "*I'm not allowed to fail because I am XX- they will get rid of me*". Even though she admitted to "*a lot of imposter syndrome*", her observed actions were self-driven and purposefully led her successfully though the stages of transition. The culture of the facility where Charlotte was placed demonstrated a reciprocal response and found ways to increasingly use Charlottes proven expertise as she advanced through the stages of transition.

Donna showed a similar self-fulfillment in her role which she achieved through serving and connecting with the "elders" in her care. Vogelsmeier et al. (2015) identified "making a difference" as a transition theme amongst APRNs participating in a similar study focused on quality improvement. These nurses talked about making "real change happen" and a sense of satisfaction that came from feeling like their presence and interventions were making a difference (p. 96). In one of our final meetings, Donna's narrative demonstrated satisfaction with the work she had been able to accomplish. "*We increased vaccine rates, decreased hospitalizations, decreased ED visits….. we didn't decrease falls, but we still made a difference*". Donna had successfully navigated the transition experience and was focused on the last stage in Brown and Olshansky's (1997) "From Limbo to Legitimacy" theoretical model, "broadening the perspective".

Theme 4: Provider Relationships

The relationship between the APRNs and the medical providers and/or their contracted APRNs varied from daily conversations in some facilities between APRNs and the contracted APRNS, to several that were less of collaboration and more parallel practice. Key elements of a collaborative practice include "trust, communication, role negotiation, and conflict resolution", however these elements were only partially visible between some of the study APRNs and the medical providers in their respective facilities (Kleinpell & Hravnak, 2005). This infrequent communication and minimum collaboration are supported by the literature. Martin and Alexander (2019) found in a survey of APRNS (n=3143) only 50.2 % reported communicating in person with their supervising physician at least one per month and only 56.6% of respondents (n=3551) reported their supervising physician conducted medical record reviews. In our study several facilities such as Natalie and Jenny's consisted of multiple attending physicians and their

associated APRNs, all of which communicated well and frequently with Natalie and Jenny. "*XX really did take me under their wing*" said Jenny referring to the medical agency that contracted services with the LTC. However, in Victoria and Alison's case, almost no communication was to be found and collaboration was lacking.

Empowerment is a concept of providing employees with the resources they need to capitalize on opportunities, and the authority to get work done with accountability to encourage proficiency and ideally worker satisfaction (Almost & Laschinger, 2002). The extent to which APRNs are provided support, resources and opportunities has a positive impact on empowerment which encourages collaboration with physicians and managers. The presence of structural empowerment engenders higher respect for the APRN from physicians and administrators and the APRNs are then in turn given increased autonomy and allowed greater participation in the decision processes for the organization (Almost & Laschinger, 2002). The APRNs in our study who were given resources, space, and opportunities for patient care were able to feel empowered and make better connections with their fellow medical providers. For example, Donna and Sally were given office space, immediate access to residents and support from administration. Their initial interactions with the contracted APRN and MD were positive, and Donna and Sally felt empowered to transition and realize change.

Likewise, Natalie and Jenny experienced similar levels of structural empowerment through access, resources, and support. The two APRNs reported good relationships with all contracted APRNs and their associated medical providers (three in total). I witnessed this empowerment through the weekly quality and discharge team meetings in which Natalie and Jenny were included as integral parts of the team. However, none of these relationships that I observed rose to a level of true collaboration and equal status- there always remained a feeling of

the APRNs being submissive in the face of medical expertise. Though these relationships were all respectful, further work needed to be done to ensure the APRNs in the study were given equal footing. It did not take much miscommunication for Sally to ultimately catch the brunt of a disagreement over patient billing with the MD and his contracted APRN. Sally was still empowered though through support by the administrator, but her transition was delayed due to this obstacle. However, with increased experience and time the APRNs who were successfully transitioning demonstrated behaviors that indicated they were becoming an integral part of team processes as demonstrated by Charlotte and Donna's participation and leadership in regarding the COVID- 19 pandemic response on their respective units.

A potential explanation for Sally and Donna's difficulty in relations with the MD and his contracted APRN most likely originates in a failure to communicate their role accurately to others on the healthcare team. Kleinpell and Hravnak (2005) reported "communicating about (APRNs) to employers, collaborators, patients, and the lay public is required to promote the contributions of (APRNs) as members of the health care team" (p. 178). In interviews with the MD and the APRNs, I received different messages about root cause which indicated lack of understanding. The MD created a narrative of the APRNs "*overstepping their bounds*" and not communicating, but the APRNs felt the disagreement originated in money and a territorial fight over which provider could claim what billing rights over which patient interactions. Any successful future transition programs intentionally made for embedded APRNs in the LTC setting should include training and focus on how to negotiate patient care between multiple provider teams to ensure harmony and aid a successful transition for any new APRN providers.

Another potential barrier to provider relationships is the question of Autonomy and APRN right to practice. In spite of the IOM's 2011. *Future of Nursing* report which calls for

nurses to practice to the full extent of their licensing, APRNs in Texas are required to enter into a collaboration practice agreement (CPA) for oversight by a physician. At the onset of this study, the MD for all five of the LTC facilities agreed to a supervisory role for the APRNs and signed CPAs with the APRNs assigned to their facility. Theoretically, from a transition standpoint, these collaborating physicians have the promise to serve a role-model and mentor for these APRNs new to practice in this LTC setting. In fact, the AACN *APRN Clinical Preceptor Resources Guide* (n.d.), states that APRNs, *physicians* and physician assistants are all partners in clinical education and responsible for enculturating APRNs into advanced practice. However, as the literature supports, "40-50% of respondents reported irregular contact with their supervising physician, and no formal review of their medical records" which was similar to what was observed in this study (Martin & Alexander, 2019, p. 27). The power differential created by this supervision structure does little to create truly collaborative teams and fails to "institutionalize potentially important checks on early career professionals" (Martin & Alexander, 2019, p 29).

Theme 5: Individual vs. Organizational Caretaker

A survey of NPs (n=698) y Hart and Bowen (2016), reinforced new APRN reliance and even preference for primary one-on-one patient care. The survey reported, with a range from 1 (very unprepared) to 5 (very prepared), an average score of 4.3/5 (SD 0.86) for reported preparedness to practice health assessment. Conversely, M 2.3/5 (SD 1.26) reported preparation for billing and coding and 2.46/5 (SD 1.59) reported preparation for simple office procedures, revealing less comfort with regulatory and quality management tasks (Hart & Bowen, 2016). This was reflected in the APRNs overall discomfort and struggles with identifying how to bill for services rendered and also with their overall discomfort with gathering and analyzing quality improvement data. In fact, the pull to find legitimacy through nursing skills including

assessments and evidence-based practice (M-4.30, SD 0.93) paint the picture of a new practitioner using nursing level skills (Hart & Bowen, 2016). In a similar vein, Spoelstra & Robbins (2010) identified a sub-theme of "importance of direct patient care" nestled within the overall theme of "the essence of nursing". Identification of this theme further reinforces the idea that APRNs place primacy on the importance of physical and holistic assessments and prefer to be seen as caregivers to the individual as opposed to caretakers of the social context of their daily practice.

The last step in Brown and Olshansky's (1997) "From Limbo to Legitimacy" theoretical model is Broadening the Perspective, implying the nurse has looked beyond their personal practice and is attending to the organization, culture, or system within which they work. "Enhanced self-esteem" allows the APRN to reflect upon their experiences and are consciously taking on new challenges. Only a few of our initial sample of 9 APRNs made it to this stage of transition. Several became stagnated in the earlier stages of Launching and maybe even Meeting the Challenge, which focuses on starting their new role as a practitioner through feeling more settled with a greater sense of legitimacy. Kelsey was unable to embrace her role as a provider beyond the first few months when she was clearly stagnating in the Launching stage, and she never made it to a point of increasing confidence and left the study altogether. Victoria and Alison met the same fate, and never truly embraced their role as quality improvement professional to care for the organization, not just the individual patients within. However, to some extent Sally, Donna, and Charlotte were able to advance, find legitimacy and find more systems-based ways to help their facilities beyond just daily patient care.

Implications and Opportunities for Future Study

Implications for APRN Transition to Practice

APRNs are more likely to work in underserved settings, such as LTC, and therefore programs should be developed to support transition to practice into these unique settings. Mackay et al. (2018) identified over 50% of APRN respondents (n-159) felt unprepared and that the first year of APRN practice was difficult. Likewise, 86% of these respondents considered transition programs to provide value and benefits for future practitioners (Mackay et al., 2018). The American Nurses Association (ANA) offers credentialling of nursing TTP programs through the American Nurse Credentialing Center (ANCC) which has identified best practices for program design and quality assurance (ANCC, 2020). This credentialing relies upon individual programs to identify the exact content of their programs but does evaluate them based on use of evidence and outcomes. They have also identified nursing organizational enculturation (OE), and practice-based learning (PBL) as necessary components of a transition program (ANCC, 2020). Based on the findings from this ethnographic study, transition is threatened by a number of factors while being bolstered by others that help identify necessary components of any successful transition program for the LTC setting. Through analysis of these characteristics, I will make suggestions on important features to include in any TTP program for the LTC setting.

During the beginning stages of transition, it is not uncommon for the APRNs to suffer from imposter syndrome and potentially spend a prolonged period of time in the liminality stage between two identities: RN to APRN or even APRN from one practice setting to another (Brown & Olshansky, 1997). As Charlotte said, "*I'm confident, I'm smart, but*…..", leaving the remainder open to interpret she was struggling to feel self-self-assured and secure in her identity. Identity confusion is to be expected in a transition period as transformation is required for to

move from one state to another, but at what point does this feeling of inadequacy prevent progression to later stages in the transition process? An intentional transition program could include training on the stages of transition and acknowledgement that feelings of insecurity and inadequacy are a normal part of change and make suggestions for negotiating this process (MacLellan et al., 2015). Transition is always a transformation negotiated within a social context, indicating that education around understanding and negotiating within their historical, institutional, and social context could help further understanding and cooperation (Crafter & Maunder, 2012). Finding platforms for APRNs to discuss these transformations and to share their understanding of cultural and social contexts for change can help individuals navigate their first year in a new setting and should focus specifically on the unique characteristics of working in LTC.

Enculturation is important to set expectations and build a cultural identity, especially in a setting as unique as LTC. ANCC (2020) recommends that intentional organizational enculturation as an integral part of any transition program because it "is the process by which participants are assimilated into the culture, practices, and values of an organization or practice setting" (p. 17). Through making culture evident, APRNs have the opportunity to develop practice and values that embody culture. Enculturation also is a great opportunity to capture, enhance and celebrate the intrinsic factors that APRNs bring with them into their professional practice and amplify the attributes that will contribute to transition and socialization into the LTC setting. Our sample of APRNs identified self-fulfillment as a vital part of their transition experience and the ability to accomplish practice that met their own personal definition of what it meant to be a nurse and an advanced practice nurse was crucial to whether they successfully transitioned into continued LTC practice. Setting mutual expectations and sharing culture can

help find areas of alignment and facilitate APRN self-fulfillment in practice through the transition process.

In terms of self-fulfillment and intrinsic factors, more research needs to be done into how to capitalize on the most relevant factors to longevity in the unique setting that is LTC. IT was obvious from the beginning that each APRN brought an individual life perspective that either helped or hindered their transition. Self-efficacy was evident in some like Charlotte who overcame less than welcoming circumstance, while others were unable to engage and embed themselves into the setting and culture of the organization, like Kelsey. While transition programs can help potentially overcome or reframe some internal factors, it would be beneficial to select APRNs already primed for practice in the long-term, medical yet home-like setting of LTC. Further research should be done on the intrinsic factors that pair best with this unique practice setting.

Mentorship is also a powerful tool for helping new to practice environment APRNs understand historical, cultural, and social contexts of nursing practice acts to transfer into the community of interest. Though none of the ARPNs in the study specifically mentioned a mentor as being desired, many voiced concerns like Charlotte, "*I get overwhelmed and don't know where to start*". Mentorship by a colleague in a formal orientation program has been associated with improved NP role transition and could be replicated here (Poronsky, 2012). However, in a study of rural APRN transition to practice, Owen (2017) noted that with distance or solo APRN practice being the norm, similar to the LTC setting, mentorship by a close NP mentor is challenging and requires retooling. With the advent of digital connectivity through platforms such as Zoom© or Facetime©, any transition program could possibly explore distance mentoring

for APRNs entering practice alone or in a new field. This could also help facilitate the use of one mentor for multiple APRNs thereby extending the network and limited resources.

Practice based learning was also identified by ANCC (2020) as a necessary program component of any nursing transition program. The study APRNs clearly identified the desire to learn as they were practicing, instead of through an isolated 2-month classroom experience. "*I felt those who had more experience would get more out of it*" said Charlotte, and Jenny confided "*they don't know what they don't know*" during class orientation. Natalie who was an APRN new to practice expressed relief that she was paired with an experienced APRN and relied upon Jenny a lot in the first few months to figure out the routine. In contrast, Kelsey was also an APRN new to practice, but she chose not to rely upon Carrie for expertise and chose to work different schedules. Kelsey both neglected to capitalize on Carrie's experience and never truly integrated into the LTC facility- and therefore she failed to transition and left the project early. Painter et al. (2019) identified a successful residency program for NPs at a large medical center where 50% of the resident's time was spent in direct patient care vs. 50% in the classroom or simulation setting. NPs expressed high satisfaction with the program and residents were also able to achieve their revenue targets even with reduced workload in the beginning. Though acute care is not generalizable to the LTC setting, the concept of in-person practice mixed with classroom learning is a viable and potential design for an LTC TTP, which is desired by the study APRNs.

A component of practice-based learning, mentoring can help model for the recipient important patient healthcare techniques as well as help explain the decision processes required to care for truly complex patients (Mackay et al., 2018). Mentoring can assist with networking which is overall beneficial to help the new APRN learn more about practice within their organization, specialty, or geographical area (Kleinpell & Hravnak, 2005). Finally, mentoring

can relieve stress and anxiety which are known to be high during that first year of transition to practice. Relief of stress allows the APRN in transition to further process and develop through the stages of transition by providing perspective (Hill & Sawatzky, 2011).

Physicians can even serve in a mentorship role for new APRNs, yet this model is not as common. Even though APRNs are required to sign a CPA which is meant to contract a supervisory collaboration and compensate providers for time invested in consulting with and supervision of APRNs, in reality the CPA institutionalizes oversight and not necessarily camaraderie and mentoring (Martin & Alexander, 2019). The literature also confirms that these relationships do not always work as intended with one study showing only about 50% of respondents reported actual collaboration or contact with their supervising physician (Martin & Alexander, 2019). Instead of providing opportunities for growth, the CPA often codifies subservience, and the costs of these CPA may even hinder APRN participation in underserved communities due to cost burden (Martin & Alexander, 2019). Yet having a provider as the mentor that is a physician has enormous promise to impact the APRN ability to transition and allow the opportunity for the provider to also learn the practice of others, improving interdisciplinary activities (Sullivan-Bentz, 2010).

This relationship would benefit from further research, reimagination and exploration of limitations to identify potential for improvements. More must be done to understand the opportunities for collaboration and how to overcome some of the historical adversarial nature of the "turf wars" that have developed between APRNs and physicians if healthcare is to truly become patient-centered as espoused by the IOM "triple aim" and both the American Nurses Association (ANA) and the American Medical Association (AMA) statements and ethics (ANA, 2016; Millenson et al, 2016). A better understanding of APRNs as not replacements, but

collaborators may be beneficial in reframing the resistance of the AMA and instead focus on opportunities for shared education and practice. In populations clearly abandoned by medical providers in terms of practitioners choosing these fields, it is disingenuous to prevent other practitioners from filling in the void and caring for those populations who are historically overlooked and underserved.

Autonomy is another factor that should be investigated further to understand its implications on APRN transition to practice, the need for oversight and the collaboration. Autonomy is noted as a predictor of turnover intention in new to practice APRNs, with greater levels of autonomy being inversely associated ($b = -.63$, $p < .001$) with lower intention to leave in a population of new to practice primary care NPs (Faraz, 2017). Indeed, in this this study (Faraz, 2017), autonomy was the strongest statistical predictor of turnover in new to practice NPs and quality of the interprofessional relationships was not statistically significanct ($\beta = -.12, t = -1.00, p = .32$). Perhaps this indicates a needed balance between mentorship, but also allowing APRNs to independently practice and make care decisions. Further research is needed into the relationship between job satisfaction, intent to leave and successful transition to practice.

Any transition program must include organizational based training if APRNs are to grasp their role as an organizational caregiver. APRNs routinely express their preference for primary patient care over administrative level concepts, but when embedded in an institutional setting such as LTC, then they must necessarily be involved in organizational care (Hart & Bowen, 2016; Spoelstra & Robbins, 2019). Mentoring with fellow APRNs or physicians can help make clear the cultural importance of quality monitoring and administration, and practice-based learning can include classroom or in person experiences focused on organizational care. Intentional mentoring with administrators can also help form interprofessional practice and

establish relationships that will further guide and help the new to setting APRN transition appropriately. Future investigation into creative modes of mentorship that are affordable and achievable for the LTC are needed with a specific focus on how mentorship assists APRNS successfully transition and remain in a position in the LTC environment.

This study was carried out with new to practice APRNs as well as APRNs with experience in different settings. Both populations experienced their own unique challenges and brought their own unique facilitators to their transition experience. Review of the literature found little in the way of addressing new to practice APRN experiences, and none were found which addressed the setting of LTC specifically. Future research should focus on how new to practice and new to environment differs from APRNs who come with some experience in a different field yet still have to transition to a new practice reality. With the information on similarities and differences in the TTP experience, programs can be designed that address the unique circumstances of both populations. This could even incur cost savings if aspects of the transition could be shared with some breakout features focused on the two different circumstances, as well as savings in terms of retained personnel.

Implications for APRN Preparation and Education

Quality Measures.

APRNs typically receive a 2-3 year graduate level education, usually focused on the Master's level of education. In 2008, the APRN consensus workgroup set out to define current and future APRN practice, education and accreditation, and regulation through a consensus model (CM). The APRN was defined as a nurse with advanced preparation in direct patient care, who also had "a component of indirect care", but "retained a significant component of the education and practice focuses on direct care of individuals" (APRN consensus work group,

2008, p. 7). This CM was further codified into education competencies through the AACN Master's Essentials which outlines curriculum content and expected competencies for graduates of APRN programs (AACN, 2011). While the APRN CM is a position statement focused on *practice* models of nursing, the AACN Essentials are required curricular elements for education focused on *all* master's-level nursing programs, including direct and indirect patient care roles.

Embedded within the nine Essentials are concepts which direct preparation for both direct patient care and indirect care including organizational, systems and public health concepts. For example, Essentials II: Quality Improvement and Safety, defines APRN education in regards to "recognize(s)… must be articulate in methods, tools, performance measures, and standards related to quality" as well as "apply quality principles within an organization" (AACN, 2011, p. 4). So necessarily, the APRNs in this study were educated under these competencies and have received training in direct and indirect care.

Interestingly, the APRNs were quite comfortable and vocal in their preference for direct patient care, and showed competence yet great discomfort in their organizational, indirect care responsibilities. For some of our APRNS, these two sides of practice were almost at odds with each other and caused great internal conflict interrupting transition to practice. However, multiple previous studies have shown that APRN participation in quality improvement monitoring demonstrates improvement in quality measures in a variety of settings, including LTC (Kaasalainen et al., 2015; Unroe et al., 2015; Rantz et al., 2017; Evans et al., 2019). Tappen (2017) identified interrelated barriers and facilitators to a quality improvement initiative (INTERACT®) in nursing homes. Many of the themes identified were seen in our population of APRNs including resistance to change, competing demands, leadership instability, and organization wide involvement. The APRNs felt competing sides of their self-identity between

direct and indirect care, which diminished their enthusiasm to participate in QI measures. As enthusiasm and a champion are required for sustaining culture change, this lack of enthusiasm for the QI role is a threat to the continued value and participation of the APRNs in quality measures (Tappen, 2017).

The general consensus found in the literature and promoted by APRN certification organizations, is a practice model of holistic care based on competencies originating in the RN education. However, upon closer reading of the APRN CM statement, the definition of an APRN focuses on clinical experience, responsibility for health promotion or maintenance and acquisition of advanced clinical knowledge and skills instead of organization or systems level competencies. The statement actually intentionally differentiates direct vs. indirect care and emphasizes the primacy of direct patient care in the APRN model. APRNs are adept at holistic care in regard to a patient, but perhaps not as much when it comes to holistic care of the organization. This has implications for placement when an organization chooses to employ an APRN in a role that requires systems-level thinking, knowledge, and acumen. Though their educational program specifies they have been exposed and learned organizational, indirect care concepts, their practice model emphasizes direct care over indirect.

When I interviewed the APRNs, I tried to get to the bottom of just what level of quality measures experience and training they had received in school, and for those new to LTC setting but not new to advanced level practice I asked what experience they had in their previous positions. Donna reported extensive experience with quality measures because she had run her own NP-led clinic for 2 years, and Sally reported on-the-job training in her previous LTC RN role. Conversely, Carrie who had previous APRN practice reported little quality measures involvement in her previous position. Kelsey, Natalie and Charlotte were all new to advanced

level practice and reported small QI projects and papers in class but verified the dominance of direct clinical training in their education.

I was interested in comparing the APRNs experience with the medical training physicians receive for participation in organization care. For this, I interviewed an academic administrator located at a Medical College in the local area. Per Dr. O, the concept of "*the business of medicine*" is threaded throughout courses from their first semester through graduation. Medical students are taught to use data and quality to manage a clinic and meet all regulatory and billing requirements. As medical providers can practice independently or as part of an organization, all are taught how to run their own clinic as means of preparation. They are taught to understand management concepts and even have an entire course dedicated to the "business of medicine".

Given this level of training and indoctrination, I expected the medical providers to be more involved in quality measures than I witnessed during the course of this study. The consultancy nature of their care arrangement in the LTC led to a feeling of detachment and I did not see great levels of involvement in quality measures. This created a natural opening for the APRNs to step in and help run the quality improvement programs given their embedded position, holistic/wellness training, and health promotion outlook; however, profound discomfort with this role impaired several of our subjects from stepping into this position and warrants further investigation.

Potential solutions to this issue include preparing APRNs to better address learning organization and public health level concepts. Since 2004, a doctorate level education has been endorsed by American Association of Colleges of Nursing (AACN) as the entry to nursing practice called the Doctor of Nursing Practice (DNP) (AACN, Oct. 2020). The move to recommending the DNP originates in the increasing complexity of the healthcare system in

America which “requires a higher level of preparation for leaders who can design and assess care” (AACN, 2020, bullet 2). A review of master’s level curricula in 2004 exposed an expansion of courses in response to increasing demands that exceeded the typical credits and timeframe of the usual master’s program, indicating current programs were not enough (AACN, 2004). In their white paper “The Impact of the DNP on the Health of Texans, a focus group of administration focused DNPs reported their leadership had enhanced the quality of care, leadership, guidance, and creativity within their organization, but more research is needed (Boswell et al., 2021). In fact, the Texas Higher Education Coordinating Board (THECB) has delayed approval of more DNP programs in the state because of the significant cost burdens associated with increased clinical hours and the perceived lack of demand for this role (Texas Higher Education Board [THECB], 2013). Based on the findings from this study, the APRNs did indeed feel unprepared to fulfill this role and required mentoring in order to fulfill their quality measures duties. More research is needed to understand the impacts, feasibility, and viability of the DNP role.

Implications for Caregiver Roles and Responsibilities in LTC settings.

Residents of LTCs are becoming more and more complex in their acuity levels, due to shorter hospital admissions and increasingly complex medical interventions. LTC facilities are fairly complex care environments with multiple regulatory responsibilities (secondary only to the nuclear industry in terms of regulation), which are responsible for medical care management but also creating a “homelike atmosphere” which keeps resident satisfied, stimulated, and engaged (Zinn et al., 1995; Tappen et al., 2017). However, the majority of LTC care is actually provided by certified nurse assistants (CNA) who receive a minimum amount of training (usually 8 weeks), often not including special training in geriatric care (Guo & McGee, 2012**)**. CNAs are

among the lowest paid healthcare workers leading to high turnover and low morale, yet these CNAs are entrusted with overseeing the care of our nation's most vulnerable persons often resulting in sub-standard care (Guo & McGee, 2012; National Center for Health Statistics [NCHS], 2019).

Within the LTC facility in the U.S., nursing care is represented by either RNs or Licensed Vocational Nurses (LVN), Licensed Professional Nurse (LPN) and a Director of Nursing (DON). According to the National Center for Health Statistics (2019), in nursing homes 11.9% of full-time equivalents (FTE) care is provided by RNs, while 22.4% are provided by LVNs which also varies by geographic area. This contrasts with, as stated previously, the majority of patient care is provided by CNAs, at 63.9% of FTE care. The average total nursing hours per day (combining RNs, LPNs, LVNs and CNAs) was 3hours and 48 minutes, with only 1hour and 23 minutes of that time being provided by an RN, LPN or LVN (NCHS, 2019). In the state of Texas, LVNs are trained to perform focused assessments only, and to care for residents with predictable conditions whereas the RN is educated to perform comprehensive assessments and is positioned to identify residents with changing and deteriorating conditions (Texas BON, 2021a; Texas BON, 2021b). Therefore, LTC centers have reduced capacity for recognizing detecting early signs of residents with illness who are decompensating and avoiding the need for hospitalization.

Theoretically, the DON position in the LTC can fill the supervisory role for LVNs as they are required to be an RN level practitioner with the requisite training and skills for that license, but no further DON preparation is required (Texas Health and Safety Code, 1997; Siegel et al., 2010). The DON is largely responsible for administrative duties

including ensuring nursing staffing, quality monitoring, and regulation compliance; however, given their status as an RN, they are often called upon to fill in as charge nurse and even staff nurse and the mental requirements to supervise LVN practice leads to scope expansion and overextension (Siegel et al., 2010). To further the difficulties with patient oversight and catching signs and symptoms early enough to prevent hospitalizations is the turnover rate for these caregivers: 41% for RNs, 50% for LVNs/LPNs, 66% for unlicensed caregivers, and 38% for DONs, (Siegel et al., 2008).

Medical services are usually not embedded within LTCs meaning that day-to-day medical care and supervision is often provided by a community-based attending physician or an associated "appropriately supervised midlevel practitioner" such as an APRN or Physician's Assistant (PA) to

> "visit(s) patients in a timely fashion, based on a joint physician-facility-developed protocol, consistent with applicable state and federal regulations, depending on the patient's medical stability, recent and previous medical history, presence of significant or previously unidentified medical conditions, or problems that cannot be handled readily by phone". (Institute of Medicine (US) Committee on Improving Quality in Long-Term Care, 2001; AMDA, 2003, List 3, Bullet 1).

Federal regulations also require that LTCs employ a Medical Director responsible for supervising medical care in the LTC as well as developing administration policies in concert with other LTC administrators, helping guide quality assurance, promoting person-directed care, educating nursing and medical staff on latest standards of care, and staying abreast of latest federal and state regulations (Nanda, 2015; Stefanacci, 2019). Some MDs are also the main attending physician often contracting with other providers

under their supervision, such as APRNs, and MDs are expected to cover for attending physicians when they are unavailable (Nanda, 2015). Yet with all of these roles to fulfill, a survey conducted by the Department of Health and Human Services, Office of the Inspector General (2003) found that 86% of MDs reported spending 8 hours or less per week at their facility, and 70% reported spending only 1-10% of their medical practice time committed to the MD role (Office of Inspector General [OIG], 2003; Nanda, 2015). For those times that an attending physician is not in the facility, nursing is expected to notify either the attending physician (if he/she is a different individual than the MD), the MD, or the DON for further direction in case of resident emergencies requiring medical care: however, this requires the nursing staff to be attuned to patient conditions of which they may not be trained (OIG, 2003). All of these factors lead to a system that relies on consultancy instead of ownership of the overall patient care by a practitioner with diagnostic expertise, revealing potential gaps in coverage for early illness detection to identify residents in need of intervention and medical attention *before* needing hospitalization.

APRNs hold promise to fill this gap with their expertise that bridges both nursing knowledge and medical knowledge to provide timelier and more targeted patient care for LTC residents. The IOM report, *Improving the Quality of Long-Term Care* (2001), identified APRNs as potential "substitutes for physicians"; however, Trotter (2020) argues that NPs identity is "grounded in assertions of difference, not interchangeability" with a "claim(s) to different expertise" (p.18, p. 21). In her study of NPs working in a federally funded clinic, Trotter (2020) identified these APRNs had a deep knowledge about their patients that extended the clinical exam encounter "beyond the walls of the

exam room" and provided value to member and their families through a "different orientation to patient care" (p. 33, p. 20). Focusing not just on the patient's medical presentation and diagnosis, allows the APRN to concentrate on the whole person including family dynamics, psychosocial pressures and "conditions of daily living" (p. 44). The dominant physician approach to patient care is one of constructing a "medical narrative" which attempts to "tame chaotic" patient stories and presentation (Frankel, 1990; Trotter, 2020, p. 38). Embracing the complexity of patient life and illness allows APRNs to be better positioned to care for complex residents in an LTC environment where their conditions are not just medical, but also psychosocial, role adjustment, and familial in nature. Even the structure of a nurse-physician collaboration agreement implies consultation on the part of the physician, which further supports the role of the APRN as embedded expert owner and holistic care provider for LTC residents.

APRNs can use their status as different than both nurse and medical practitioner, to cross between the two enabling interprofessional care from all levels of HCP in the LTC setting from CNA to Medical Director. Hurlock-Chlorostecki (2015) found that APRNs, including in the LTC setting, were adept at brief interactions of 2-3 minutes which accomplished interprofessional patient care known as knotworking. During these interactions, the work of "tying, untying, and retying of separate threads of activity by loosely connected people" is accomplished to provide care but does not always result in interprofessional care (paragraph 14). Knotworks and brief interactions were achieved more often by APRNs than other HCPs and the interactions initiated by APRNs were twice as likely to be focused on interdependency to create shared decision-making and information sharing which are critical to interprofessional patient care (Hurlock-

Chorostecki, 2015). Other HCPs identified APRNs as central to these knotmaking scenarios and noted they were responsible for carrying "continued threads" of information they could use for future knotmaking sessions giving APRNS centrality to patient care but also continuity of information (para 22). APRNS could serve as a bridge between professions "translating information and knowledge as an equal" becoming a "link" between professionals, and their unique position as medical providers allows for quick and informed action (Hurlock-Chorostecki, 2015, para 25).

Limitations of the Study

This qualitative ethnographic study was conducted in the LTC setting, meaning it may not be generalizable to other APRN practice settings. The sample was purposeful in nature and consisted of the APRNs already identified and hired to participate in an TXHHS investigation of quality improvement with the use of an embedded APRN. The sample included APRNs with different education backgrounds and certifications including Clinical Nurse Specialist (CNS), Acute Care Nurse Practitioner (ACNP) and Family Nurse Practitioner (FNP). However, as this research was qualitative in nature and interested in the experience of APRNs in LTC (which consists of practitioners from a wide variety of training backgrounds but all with the same advanced practice credentialing focus) the variety of participants backgrounds was not concerning. Indeed, it enhanced the theoretical implications of the study.

The nature of ethnography is that it requires lengthy interactions and observations to draw meaningful interpretations from the interaction of the subjects and their environment. Were the observations made enough? Were there themes left untapped? The researcher is the tool of interpretation which relies upon the "fable of rapport" (Clifford, 1983). Was the researcher able to establish sufficient rapport to get honest accounts from the subjects? While the researcher can

never know, there is comfort in the credibility established in the research design and trustworthiness established in the triangulation with participants and consultation with the academic advisor. As an ethnographer I worked to balance the search for true epistemological knowledge with personal epiphanies to keep the interpretation focused and at the center. A risk is that the balance will be off kilter and the analysis will be too confessional or conversely too dry and unpalatable. Through trustworthy processes, I worked closely with an experienced ethnographer who challenged my interpretations and thoughts in order to strengthen and focus the findings where environment and subject meet to create shared culture.

Acknowledgement must be made that the CAS identified in the conceptual model (Figure 1) includes LTC residents as a component of the system, yet they were not included in the purposive sample for interviews (Table 4). This was due to patient confidentiality issues and concern for privacy. This also necessitated ensuring interviews were focused on eliciting rich descriptions of the patient care environment from others in the LTC setting.

A major limitation to all research in this present time is the COVID-19 pandemic, which forced me out of the LTC facilities with approximately 2 ½ months left of observations. This necessitated a change in focus to continued remote interviews via a videoconferencing platform, but also disrupted the roles and responsibilities of the APRNs. The nature of our conversations switched from one of transition to one of crisis management. The stress of an unfamiliar pathogen that was raging through LTC facilities across the U.S. was unsettling and interrupted most of the transition processes. It did, however, provide a unique window into how APRNs can help LTC facilities in a time of crisis. Even though this was not the main focus of the study, upon further analysis the crisis caused by the COVID-19 pandemic did amplify the transition

experience of the APRNs. The crisis revealed those who were accepted and a part of the solution within their facilities and exposed those who were not.

Finally, I must address that this study approached the idea of transition to practice with new APRNs and as experienced APRNs who are new to the setting conceptually together. This is an appropriate approach because the ethnography does not come in looking for preconceived connections formulated in theory, but instead is guided by a theoretical framework of world perspective. Complexity science and CAS were particularly useful as each APRN was viewed as their own CAS with potential for transition that was interdependent on the organizational culture as well as their own intrinsic worldview.

Summary

This study establishes understanding of how APRNs transition to practice in the LTC setting, whether new to advanced practice altogether or new to the practice environment of LTC. While transition of RNs to practice is fairly well-studied, the transition of the APRN is necessarily different given their expanded scope of practice and the different environments in which they work, so parallels can not necessarily be drawn. The nature of collaboration is also different in a state which requires a CPA between the APRNs and physicians, meaning that there is an extra element and power dynamic to navigate that does not exist at the RN practice level. Similarly, transition of APRNs has recently been explored, but not in the unique LTC setting. The guiding theoretical framework of CAS and complexity allowed for me as the ethnographer to remain open to observing attractors, both facilitators and barriers, to successful transition as a confident APRN and practitioner in the LTC setting. Themes were construed which parallel other observed APRN transition experiences in the literature, but also reveal idiosyncrasies to the LTC setting that warrant further exploration.

APRNs are more likely to practice in underserved areas, such as LTCs and primary care, meaning they are more likely to serve vulnerable populations. (Buerhaus et al., 2015). Developing programs which increase the ability of APRNs to transition to and function within these environments has promise to decrease disparities and inequities all too common in healthcare. As the US population ages and more individuals will need LTC services, we are simultaneously met with a decline in available physicians specializing in Geriatrics. APRNs specializing in primary care and geriatrics are increasing and can fill this role but should not be considered as mere physician replacements. The unique educational focus on holistic care, organizational care and person-centered care makes nurses able to be more than just the provider and potentially organize care in a more coordinated way. LTCs are environments which balance medical needs while also being the residents' home, so APRNs are uniquely suited to help manage and create the wellness, patient-centered environment that this vulnerable population needs.

However, in order to bring more APRNs into the LTC setting, we need to support their transition in a more comprehensive and informed way. Burnout and failure to successfully transition are real risks and must be mitigated with more knowledgeable practices. This study adds to our understanding of what these successful programs will need and informs future research by valuing and listening to the APRNs themselves. Observing co-created culture reveals the intersection and interdependence of the LTC and the APRN- it is here where we can find ways to improve upon both.

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